CURRENT ISSUES

Workers' Compensation Conference

March 16, 2018

Sponsored By:

Law Office of Richard L. Montarbo

CURRENT ISSUES
WORKERS' COMPENSATION SEMINAR

Friday, March 16, 2018

The Citizen Hotel
926 J Street, Sacramento (916) 492-4420

8:00 a.m. - 8:45 a.m.	**Registration**
8:45 a.m. - 10:15 a.m.	**Introduction and Opening Comments:** **CaseLaw Update** Richard L. Montarbo, Esq. *Law Offices of Richard L. Montarbo*
10:15 a.m. - 10:30 a.m.	**Break**
10:30 a.m. - 12:00 p.m.	**Cumulative Trauma and Apportionment of Liability** Arjuna Farnsworth, Esq. *Boxer & Gerson* Michael Giachino, Esq. *Hanna, Brophy et al*
12:00 p.m. - 1:30 p.m.	**Lunch**
1:30 p.m. - 3:00 p.m.	**Apportionment Re-visited** **(City of Jackson v. WCAB (Rice)** Jake Jacobsmeyer, Esq. *Shaw, Jacobsmeyer, Crain & Claffey* Jason Marcus, Esq. *Marcus, Regalado & Marcus*
3:00 p.m. - 3:15 p.m.	**Break**
3:15 p.m. - 4:30 p.m.	**Orthopedic Medicine and the Med/Legal Process** Michael Charles, M.D. *Newton Medical Group* Ted Richards, Esq. *Stander, Ruebens, Thomas et al* Joe Capurro, Esq. *Law Offices of Joseph Capurro*

This seminar will be held at The Citizen Hotel 926 J Street, Sacramento, California, (916) 492-4420. The Citizen Hotel offers a more prestigious ambiance, and seating is very limited. Please confirm with the Law Offices of Richard L. Montarbo, 146 Main Street, Red Bluff, California 96080, Telephone (530) 554-1922; Fax (530) 529-9865; Website Montarbolaw.com. Brunch will be provided. All materials will be available electronically and registration includes the CompCalc Plus CV, please make sure that you bring a tablet or laptop so that you are able to download the materials prior the conference. Seminar will conclude with private wine tasting with hors d'oeuvres.

Registration Fee: $295.00 for Attorneys; $155.00 for Legal Support Staff; $60.00 for Claims Examiners and Supervisors

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Pre-registration, including payment must be received at the Law Offices of Richard L. Montarbo no later than February 23, 2018.

FEATURED AGAIN THIS YEAR

Following this year's Current Issues Workers' Compensation Conference, we will conclude with wine tasting and hors d'oeuvres complimenting each of the wine varietals

Speakers ~ Curriculum Vitae

• Richard L. Montarbo, Esq.

Admitted to California State Bar, 1987; Hawaii State Bar, 1989. Education: California State University at Sacramento (B.S., 1983); University of the Pacific, McGeorge School of Law (J.D., 1987). Admitted to Practice before U.S. Court of Appeals for the Ninth Circuit; U.S. State District Court, Northern District of California; State Courts of the State of California. Member: Shasta-Trinity County Bar Association, American Bar Association. Certified Workers' Compensation Specialist 1995. [U.S. Navy, Flight active and reserve duty, 1987-1996.]. Mr. Montarbo is a frequent presenter at various workers' compensation claims conferences including State Bar of California Workers Compensation Section, CAJAPA, DVICA as well as having provided the defense perspective on a number of occasions at the CAAA annual conference. Mr. Montarbo is also an Adjunct Professor at McGeorge School of Law, as well as the Author and Assistant Editor of the Work Comp Index: A topical guide to California Workers' Compensation Law, published by Lexis/Nexis.

• Arjuna Farnsworth, Esq.

Arjuna represents injured workers who have problems navigating through the often confusing and complex workers' compensation system. He was the lead counsel in more than 500 cases during his tenure as an associate at Brown & McDevitt in Larkspur, California. Much of his work focuses on representing police officers, firefighters, and other peace officers in workers' compensation claims. He has become an expert in the expanded benefits available to these professionals who put their well-being and very lives on the line to protect the public. Police officers associations and other unions frequently invite him to give presentations to union staff and members interested in knowing more about this specialized area of the law. After earning his undergraduate degree in political science from University of California, Santa Barbara, Arjuna went on to graduate from the University of California, Hastings College of the Law in 2003. He joined Boxer & Gerson, LLP in 2006.

• Jason Marcus, Esq.

Education: California State University, Sacramento B.A., 2005. University of the Pacific, McGeorge School of Law, J.D., 2008. Mr. Marcus is a partner with the firm of Marcus, Regalado & Marcus located in Sacramento, CA. He is a Member and Secretary of the Executive Board of the California Applicants' Attorneys Association, as well as being on the Board of Directors from September 2010 to present. he is also a member of the Sacramento County Bar Association and California State Bar Association. Mr. Marcus is a Certified Specialist, Workers' Compensation since July 2014. He has also spoken as a panelist at a number of CAAA Conventions and Seminars and currently serves on CAAA Executive Board.

• Michael Giachino, Esq.

Education: University of California, Berkeley B.S., 1974, Graduated with honors. San Francisco Law School, graduated with a Juris Doctor. Mr. Giachino joined Hanna Brophy in 1985 becoming a Partner of the firm in 1989. Mr. Giachino is currently a Senior Partner and Managing Partner for the Oakland Office. He handles all types of workers' compensation claims at any level of complexity. Mr. Giachino provides Workers' Compensation Defense, Labor Code Section 132a, Serious and Willful Misconduct, Insurance Defense and Workers' Compensation Subrogation for Hanna Brophy.

• Richard M. Jacobsmeyer, Esq.

Education: St. Mary's College 1968-1972, University of Santa Clara School of Law, (J.D., 1975) graduated cum laude. Currently employed with Shaw, Jacobsmeyer, Crain, Claffey & Nix as a Partner of the Oakland office. Member: Certified Workers' Compensation Specialist since 1981, Industrial Claims Association, Seminar Chair. CAAA, Board of Governors 1986-1990, 1992-1994. NCAAA, Board of Governors Treasurer 1987-1988, Secretary 1988-1990, President-elect 1990-1992, President 1992-1994. Affiliations: California State Bar, California Workers' Compensation Defense Attorneys Association.

• Ted Richards, Esq.

Education: Graduate of University of California, Hastings College of Law, JD. Received Bachelor's degree in Political Science from Stanford University. Has been a member of the California State Bar since 1985, with an extensive legal background including experience in personal injury, insurance defense, and appellate work. Mr. Richards' workers' compensation experience began in 1989 and has involved both applicant and defense practice. He frequently lectures on workers' compensation matters and has presented to CCWC, the Sacramento County Bar Workers' Compensation Section, the Northern California Workers' Compensation Defense Attorneys' Association, the Association of Worker's Compensation Professionals, the Valley Industrial Claims Association, the California Self-Insurers' Association, the National Workers' Compensation and Disability Conference, the California Association of Joint Powers Authorities, the Public Agency Risk Management Association, and at many other industry events. He joined Stander Reubens Thomas and Kinsey in 1999, and is a shareholder and the manager of the firm's Sacramento office.

• Joseph Capurro, Esq.

Education: Graduate of California State University, Hayward, (BA, Political Science) and JD from University of Santa Clara School of Law (1980). Admitted to the California Bar in 1980. He is a sole practitioner at The Law Office of Joseph V. Capurro in San Jose, CA, and has represented injured workers before the Workers Compensation Appeals Board and Courts of Appeal since his admission to the Bar. Currently, his practice is limited to such representation. Has frequently participated in matters involving Workers Compensation issues before the California Supreme Court and various California Courts of Appeal, including the recent Stevens v. WCAB case as Amicus in support of the Petitioner. He is an active member of the California Applicants Attorneys Association and currently serves as the Secretary of the Executive Board. He serves on several committees of the organization and is Co-Chair of the Amicus Curiae Committee. He is a frequent lecturer on matters involving Workers Compensation, particularly on the topic of recent case law developments.

• Michael Charles, MD

Education: Graduate of Rutgers Medical School (1977), Residency, Martin Luther King, Jr. General Hospital, Los Angeles (1982). Board Certification, American Board of Orthopaedic Surgery, Fellow, American Academy of Orthopaedic Surgeons, Member of Orthopaedic Society for Sports Medicine, Qualified Medical Evaluator, Agreed Medical Evaluator. Dr. Charles lectures extensively on his specialty areas: shoulders, knees and back injury prevention to lay and medical audiences locally and across the country. He is an active member of Physicians Medical Foundation, American Medical Association, California Medical Association, National Medical Association, California Society of Industrial Medicine.

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(510) 286-3700 or 1 – (800) 794-6900 Fax (510) 622-3467

February 28, 2018

Law Offices Of Richard Montarbo
146 Main Street
Red Bluff, Ca. 96080

Attn: Richard Montarbo

Provider No: 620
Course: Current Issues Workers' Compensation Conference
Approved Date: February 28, 2018

Dear Mr. Montarbo,

This letter is to notify you that your course "Current Issues Workers' Compensation Conference" *has* been approved for a total of 5.75 continuing education (CE) hours for the Division of Workers' Compensation (DWC) in accordance with Labor Code section 139.2(d)(3) and Title 8 of the California Code of Regulations, section 55.

Within 60 days of completion of the course, you must send the DWC a copy of your roster listing the names of the persons who attended your course. (8 Cal. Code of Regs. §55(o).)

If you have any questions about your approval status, please call

Francine Wooley (800)794-6900
Email her at FWooley@dir.ca.gov

Sincerely,

DWC Medical Unit

THE STATE BAR OF CALIFORNIA

MCLE PROVIDER CERTIFICATION DEPARTMENT

March 5, 2018

America Navarro
Law Offices of Richard L. Montarbo
145 Main St
Red Bluff, CA 96080

Dear America,

I received your Single Activity Provider Application. It is currently pending approval.

If you have any questions, please feel free to contact me.

Kind Regards,

Derek Cañas

Derek Cañas
The State Bar of California
MCLE Provider Certification
180 Howard Street
San Francisco, CA 94105
Tel: (415) 538-2136
Derek.Canas@calbar.ca.gov

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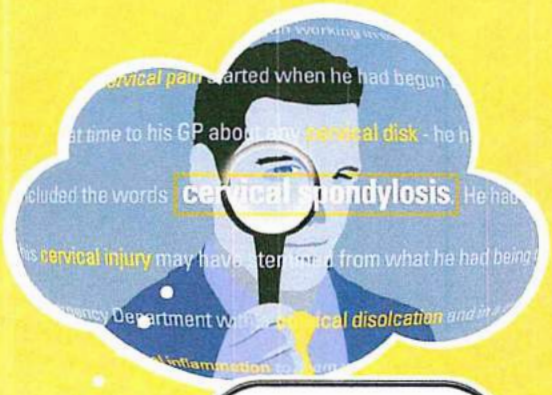

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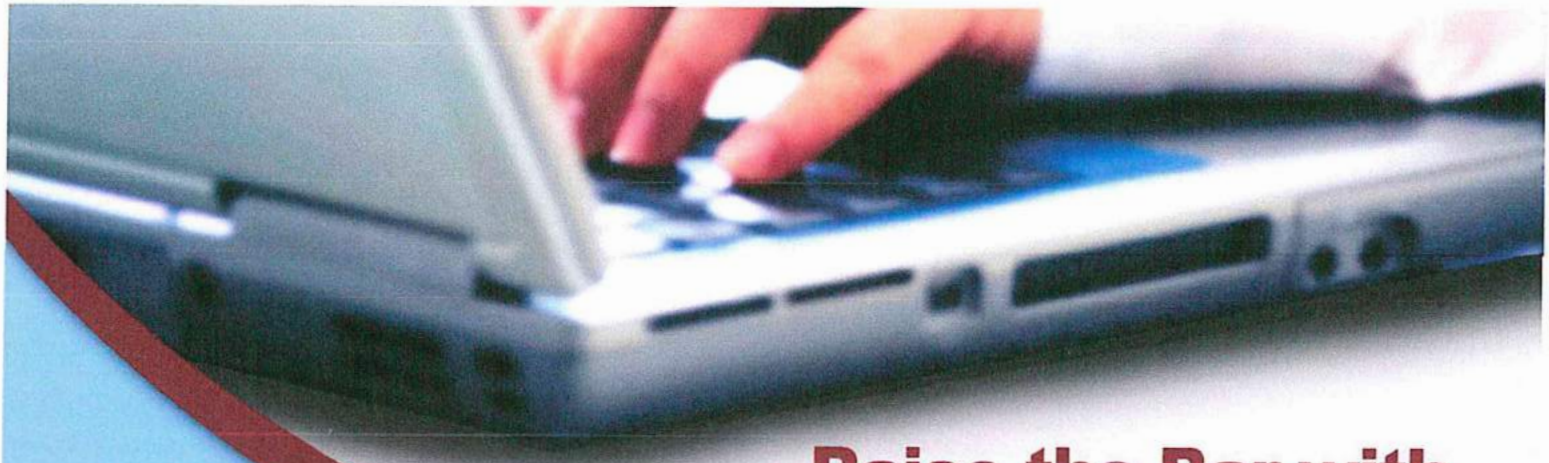

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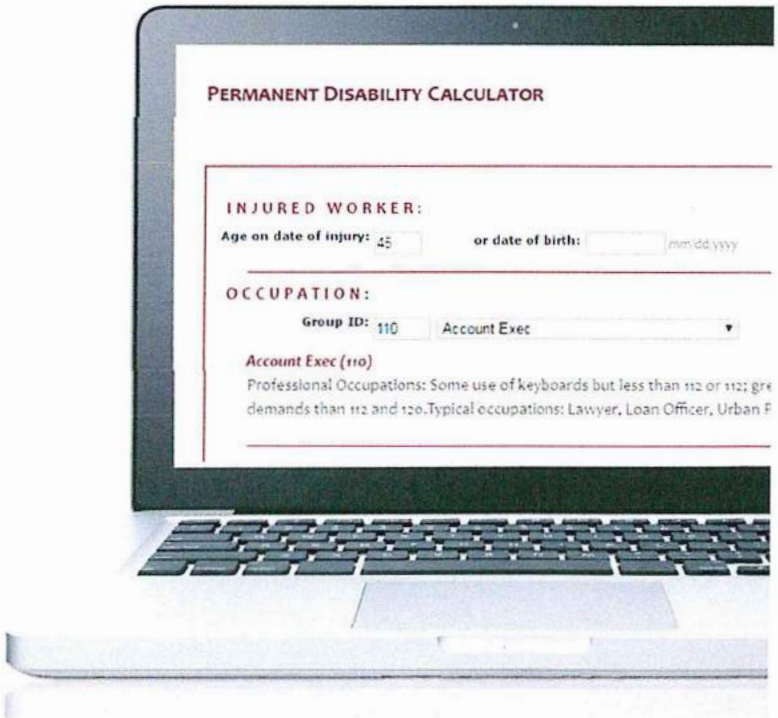

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March 2018

Table Of Contents

Hyperlink Tabs

TABLE OF CONTENTS

CUMULATIVE TRAUMA & APPORTIONMENT OF LIABILITY

By: Arjuna Farnsworth, Esq & Michael Giachino, Esq.

APPORTIONMENT RE-VISITED (CITY OF JACKSON V. WCAB (RICE)

By: Jake Jacobsmeyer Esq & Jason Marcus, Esq.

The Doctrine of Apportionment: Strict Legal Apportionment/Causation of Injury & Apportionment of Liability as Between Co-Defendants.

ORTHOPEDIC MEDICINE AND THE MED/LEGAL PROCESS

By: Michael Charles, M.D, Ted Richards, Esq & Joe Capurro, Esq.

Case Law Update

2018

Richard L. Montarbo, Esq.

Law Office of Richard L. Montarbo

CASE LAW UPDATE 2018

The following represents a summary of some of the most recent case decisions issued by the California Supreme Court, California Court of Appeal, and the Workers' Compensation Appeals Board, which the Editor believes will have significance in connection with the practice of Workers' Compensation law. The summaries are only the Editor's interpretation, analysis, and legal opinion, and the reader is encouraged to review the original case decision in its entirety.

Practitioners should proceed with caution when citing to this panel decision and should also verify the subsequent history of the decision. WCAB panel decisions are citable authority, particularly on issues of contemporaneous administrative construction of statutory language [see Griffith v. WCAB (1989) 209 Cal. App. 3d 1260, 1264, fn. 2, 54 Cal. Comp. Cases 145]. However, WCAB panel decisions are not binding precedent, as are en banc decisions, on all other Appeals Board panels and Workers' Compensation Judges [see Gee v. Workers' Comp. Appeals Bd. (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cases 236]. While WCAB panel decisions are not binding, the WCAB will consider these decisions to the extent that it finds their reasoning persuasive [see Guitron v. Santa Fe Extruders (2011) 76 Cal. Comp. Cases 228, fn. 7 (Appeals Board En Banc Opinion)]. Panel Decisions which are designated as "Significant" by the WCAB, while not binding in Workers Compensation proceedings, are intended to augment the body of binding appellate court and en banc decision and is limited to panel decisions involving (1) issue(s) of general interest to the workers' compensation community, especially a new or recurring issue about which there is little or no published case law; and (2) upon agreement en banc of all commissioners on the significance and importance of the issues presented and resulting decisions. (See Elliot v. WCAB (2010) 182 Cal.App. 4th 355, 361, fn. 3, 75 CCC 81; Larch v. WCAB (1999) 64 CCC 1098, 1099-1100 (writ denied).

I. Injury AOE/COE

Garcia v. Whitney, 2016 Cal.Wrk.Comp.P.D. LEXIS 526 (BPD)

The applicant was temporarily living rent free at defendant house. During this stay the applicant performed "maintenance activities for the house". Applicant sustained injury at an alternate address owed by defendant and sought workers' compensation benefits for that injury. The WCJ found applicant was not an employee at the time of the injury. The WCJ noted first that the applicant was injured at a different address altogether. Second, the WCJ held that asking someone staying rent free in your home to perform activities is not, in this WCJ's opinion, an offer or creation of employment unless there is evidence that declining to perform said activities would result in the "consideration" (free rent in this case) being withdrawn. The WCJ noted that the Applicant himself testified that he was never given the impression that the defendant would have him move out if he did not work. Applicant did testify that "he couldn't answer" why he felt he could not live at the house without performing work even though neither defendant ever told him that. In the absence of any evidence that the consideration (free rent) would be be terminated if the work was not performed, this WCJ could not and cannot find employment.

See also, Lee v. West Kern Water District, (5th Appellate District) 5 Cal. App. 5th 606; 210 Cal. Rptr. 3d 362; 81 Cal. Comp. Cases 966; 2016 Cal. App. LEXIS 985, where a civil claim in tort held not barred by exclusive remedy defense where employer held mock robbery applying LC 3601/02 assault exception to AOE/COE.; [Hanna, Cal. Law of Employee Injuries and Workers' Compensation Law (2016) ch. 11, § 11.02; Levy et al., Cal. Torts (2016) ch. 10, § 10.11; Cal. Forms of Pleading and Practice (2016) ch. 577, Workers' Compensation, § 577.356; Wilcox, Cal. Employment Law (2016) ch. 20, § 20.41. Sullivan on Comp, Section 2.19, Exceptions to Exclusive Remedy Rule for Conduct Outside Compensation Bargain]

See also, Rowe v. Road Dog Drivers, LLC, Insurance Company of the State of Pennsylvania, 2016 Cal. Wrk. Comp. P.D. LEXIS 622 (BPD), holding that motor vehicle accident not barred by "Going and Coming Rule" where applicant's travel to co-worker's home was not ordinary commute to fixed place of business, was undertaken for employer's benefit and to saved employer costs of reimbursing two separate trips; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.157; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.05[3][d][iv], [8]. Sullivan on Comp, Section 5.48, Special Mission – Special Errand.]

If Applicant's arguments were to be followed, anyone doing anything for anybody else is an employee. The WCJ Wrote that "at the risk of oversimplifying the issue, the case law is clear that not only must work be performed for another, but consideration must be paid to the person performing said work, *in exchange* for that work."

Yu Qin Zhu v. Department of Social Services IHSS, 2016 Cal. Wrk. Comp. P.D. LEXIS 513 (BPD)

Applicant, a caregiver with IHSS, on her way to a second client, travelling by bicycle, was hit by a motor vehicle at approximately noon. At trial the Applicant testified that she was hired by the State of California after applying to work as a caretaker in 2003; Was paid by the State of California once every two weeks, and no money or salary from the clients for whom she worked. She did not stop to have lunch between clients. On the date of the accident, she would eat her lunch at the house of the second patient before she started working. Applicant was not compensated for her transportation time between the clients' houses. Defendant denied the claim AOE/COE. The WCJ found for the applicant. Defendant sought reconsideration.

See also, Carrillo v. LLG Corporation, dba Fresco II, Employers Compensation Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 658 (BPD), holding that injury as result of MVA not compensable where occurring after consumption of alcohol when applicant returned to his workplace following end of his shift, and applicant contended that basis for liability was permissive use of alcohol condoned by employer such that alcohol use became "customary incident to employment," but where drinking occurred after his shift was completed, at restaurant/bar open to public, was not employer condoned drinking on job, applicant was not called back to work, owner not present no special meeting, event or party, nor performing service for employer, and no reasonable belief per Labor Code § 3600(a)(9) and Ezzy v. W.C.A.B. (1983) 146 Cal. App. 3d 252, 194 Cal. Rptr. 90, 48 Cal. Comp. Cases 611. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 4.20, 4.25; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, §§ 10.03[1], 10.05[6]. Sullivan on Comp, Section 5.22, Intoxication] See also, Hansen v. Par Electrical Contractor, Inc. 2016 Cal.Wrk.Comp. P.D. LEXIS 661 holding evidence of acute alcohol intoxication held substantial and proximate cause of accident as and when it occurred and bar to recovery.

See also, M.F. v. Pacific Pearl Hotel Management LLC, (2017) 16 Cal. App. 5th 693, 224 Cal. Rptr. 3d 542, 82 Cal. Comp. Cases 1304, 2017 Cal. App. LEXIS 933, holding that the workers' compensation exclusivity remedy doctrine is inapplicable to claims under the FEHA, and such claims against an employer are not subject to demurrer where the employee alleges facts that (1) employee was raped on employer property while working by drunk nonemployee; and (2) employer knew or should have known alleged rapist was on the property prior to the rape; and (3) knew or should have known that the alleged rapist presented risk of potential harm citing B & E Convalescent Center v. State Compensation Ins. Fund (1992) 8 Cal.App.4th 78, 89-92 [9 Cal.Rptr. 2d 894]; Meninga v. Raley's, Inc. (1989) 216 Cal.App.3d 79, 91 [264 Cal. Rptr. 319]; Jones v. Los Angeles Community College Dist. (1988) 198 Cal.App.3d 794, 808–809 [244 Cal. Rptr. 37]; see also Light v. Department of Parks & Recreation (2017) 14 Cal.App.5th 75, 97–98 [221 Cal. Rptr. 3d 668]. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 10.70[3][b]; Sullivan on Comp, Section 2.20, Exceptions to Exclusive Remedy Rule for Violation of Public Policy.]

See also, Miranda v. Southwest Airlines, Ace American Insurance Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 497 (BPD), which found injury where employee chased car thief as applicant's actions were normal human response and did not materially deviate from his employment, noting that employer did not discipline applicant for his actions indicating that applicant's employment was extended to include time and place of his injury). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.137; Rassp WCAB affirmed WCJ& Herlick, California Workers' Compensation Law, Ch. 10, § 10.05.]

In reversing the WCJ by split panel decision, the WCAB focus on the traditional tests of "control and right to control" and "benefit conferred". The WCAB first noted the existence of a "dual employment relationship" with applicant employed by both the State of Californian and the clients for which the applicant was a caregiver. Discussing but distinguishing *Hinojosa v. Workers' Comp. Appeals Bd*. (1972) 8 Cal.3d. 150, 158–159 [37 Cal.Comp.Cases 734] (*"Hinojosa"*).) and *Smith v. Workers' Comp. Appeals Bd*. (1968) 69 Cal.2d 814 [33 Cal.Comp.Cases 771], wrote "this case is different from *Hinojosa* and *Smith*. Here, applicant suffered injury while commuting between the homes of clients whom applicant had selected and with whom she had chosen her work hours. Unlike the ranch workers in *Hinojosa*, applicant chose her own clients and work locations and hours. In essence, applicant merely used defendant to obtain client referrals. Applicant also chose the means of transport to her clients. As with any employee who drives to work or takes some other form of transit in a "normal" commute, in this case it did not matter to defendant how applicant got to work. Applicant's travel to her clients' houses by bicycle was for her own convenience and benefit. This case also is different from *Smith* because defendant did not require applicant to have a car or bicycle. Again, there was an implied requirement that applicant get herself to work, but this is no different from the vast number of employers who implicitly require their employees to transport themselves to work by whatever means of conveyance they choose". In the end the WCAB was not persuaded that this case comes within any exception to the going and coming rule as the defendant did not have control over applicant's commute, and the benefit to defendant as a result of applicant's self-transport was indirect and minimal compared to the ease and convenience realized by applicant.

On Writ of Review, the Court of Appeal reversed holding that applicant within course and scope of employment during bicycle commute between two clients' homes, the employer knew applicant provided care to more than one home each day, and employer impliedly required the applicant to provide her own transportation which provided a direct benefit to employer, and was thus 'part and parcel' of job. Zhu v. Workers' Compensation Appeals Board (2nd Appellate District) 12 Cal. App. 5th 1031; 82 Cal. Comp. Cases 692; 2017 Cal. App. LEXIS 564; [See generally Hanna, Cal. Law

of Emp. Inj. and Workers' Comp. 2d § 4.155[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.05[3][d][ii]. Sullivan on Comp, Section 5.45, Transportation Controlled by Employer]

Davis, v. State of California, Department of Forestry and Fire Protection, State Compensation Insurance Fund, 2016 Cal. Wrk. Comp. P.D. LEXIS 611; 82 Cal. Comp. Cases 285 (BPD)

Applicant contends that he is entitled to the presumption of industrial causation pursuant to Labor Code section 3212.85, due to the fact that he "was regularly exposed to a biochemical substance (Fire-Trol) during his seven years of employment with the Department of Forestry and Fire Protection. The WCJ found for defendant and issued a take nothing holding that LC 3212.85 did not apply and that applicant had failed to otherwise establish injury.

LC 3212.85 provides,

. . .(d) The injury that develops or manifests itself in these cases shall be presumed to arise out of, and in the course of, the employment. This presumption is disputable and may be controverted by other evidence. Unless controverted, the appeals board is bound to find in accordance with the presumption. This presumption shall be extended to a member following termination of service for a period of three calendar months for each full year of the requisite service, but not to exceed 60 months in any circumstance, commencing with the last date actually worked in the specified capacity.

(e) For purposes of this section, the following definitions apply:

(1) "Biochemical substance" means any biological or chemical agent that may be used as a weapon of mass destruction, including, but not limited to, any chemical warfare agent, weaponized biological agent, or nuclear or radiological agent, as these terms are defined in Section 11417 of the Penal Code

In upholding the WCJ the WCAB on reconsideration held that the presumption of industrial causation for injury from exposure to biochemical substances in Labor Code § 3212.85 requires that the person using the chemical or hazardous materials as weapons of mass destruction "knowingly utilizes those agents with the intent to cause harm"/use of substance as weapon with intent to cause widespread great bodily injury or death. In this case the applicant's exposure during the process of refuel firefighting aircraft did not establish the requisite intent. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.138[4][p]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.07[5][g]. Sullivan on Comp, Section 5.18, Presumption of Injury]

County Of Riverside v. WCAB (Sylves) (4th Appellate District) 10 Cal. App. 5th 119; 215 Cal. Rptr. 3d 693; 82 Cal. Comp. Cases 301; 2017 Cal. App. LEXIS 269

Substantial evidence supported single cumulative injury extending throughout applicant's entire professional football career, where periods of employment were linked with applicant receiving medical treatment for injured body parts, including surgeries, medications and electrical stimulation in accordance with Western Growers Ins. Co. v. W.C.A.B. (Austin) (1993) 16 Cal. App. 4th 227, 20 Cal. Rptr. 2d 26, 58 Cal. Comp. Cases 323. Newberry v. San Francisco Forty Niners, Atlanta Falcons, Oakland Raiders, San Diego Chargers, ESIS, Tristar, Zenith Insurance, Berkley Specialty, Travelers Insurance, 2017 Cal. Wrk. Comp. P.D. LEXIS 143 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.01[2][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1]. Sullivan on Comp, Section 5.6, Defining Multiple Injury Dates]

*Applicant suffered single cumulative trauma to his heart, neck, low back, right knee, and left foot while working as correctional officer despite there were two different dates of injury under Labor Code § 5412 for applicant's heart and orthopedic injuries, but one period of injurious exposure for purposes of determining liability under Labor Code § 5500.5. Bass v. State of California, Department of Corrections & Rehabilitation, 2017 Cal. Wrk. Comp. P.D. LEXIS 213 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.01[2][a]; [*2] Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1].]*

Injury upheld as AOE/COE where applicant was in wheelchair due to nonindustrial disability and employer accommodated applicant's disability by allowing her to work from home for 10 months prior to incident, and thereby created applicant's home into worksite/workplace. Santa Clara Valley Transportation Authority v. Workers' Compensation Appeals Board (Tidwell) 82 Cal. Comp. Cases 1514, 2017 Cal. Wrk. Comp. LEXIS 129 (WD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.139; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.05[2][a]. Sullivan on Comp, Section 5.50, Home as Second Job Site]

The applicant was employed with a County Defendant employer from 1998-2010, after which he went to work for an Indian tribe from 2010-2014. All periods were as a police officer. In 2013 applicant learned from his doctor that his condition was the result of a CT industrial injury during his employment with the County Defendant. This issue was whether LC 5500.5 excluded County Defendant as the last year of employment was with the Indian Tribe Defendant.

The Court of Appeal appears to hold that pursuant to Labor Code § 5500.5, employee's cumulative trauma was limited to last year of injurious exposure, excluding Federal Indian Tribes as Labor Code § 5500.5 should not limit liability to tribal employers where the WCAB lacked jurisdiction, and evidence established that employee, while previously employed by non-tribal employer, sustained a compensable cumulative trauma injury AOE/COE. [See

generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 21.02[2], 31.13[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1][d]; Sullivan on Comp, Section 5.7, Cumulative Injury – Liability.]

II. Apportionment

City Of Jackson v. WCAB (Rice), (3rd Appellate District) 11 Cal. App. 5th 109; 216 Cal. Rptr. 3d 911; 82 Cal. Comp. Cases 437; 2017 Cal. App. LEXIS 383

Applicant claimed CT injury for the period ending 4/22/09 to neck arising out of a four year of full time employment as a police officer. Applicant was 29 years old as of the last year of the pled CT. Before undergoing surgery the applicant underwent a QME examination. The QME found the applicant's condition was caused by (1) his work activities for the city; (2) his prior work activities; (3) his personal activities, including prior injuries and recreational activities; and (4) his personal history, in which the QME included "heritability and genetics," [applicant's] "history of smoking," and "his diagnosis of lateral epicondylitis [commonly known as tennis elbow]." Dr. Blair apportioned each factor equally at 25 percent.

"In Kos v. WCAB (2008) 73 CCC 529 the worker developed back and hip pain while working as an office manager. She was diagnosed with "multilevel degenerative disease," and the medical evaluator found that the underlying degenerative disc disease was not caused by work activities, but that the worker's prolonged sitting at work "'lit up'" her preexisting disc disease. (Id. at pp. 530, 531.) The medical evaluator testified that the worker's "pre-existing genetic predisposition for degenerative disc disease would have contributed approximately 75 percent to her overall level of disability." (Id. at p. 531.) Nevertheless, the ALJ found no basis for apportioning the disability. (Id. at p. 532.) The Board granted reconsideration and rescinded the ALJ decision. (Id. at p. 532.) The Board stated that in degenerative disease cases, it is incorrect to conclude that the worker's permanent disability is necessarily entirely caused by the industrial injury without apportionment. (Id. at p. 533.) Thus, in Kos, the Board had no trouble apportioning disability where the degenerative disc disease was caused by a "pre-existing genetic predisposition." (Id. at p. 531.)". . .

In Escobedo, supra, 70 Cal.Comp.Cases at pages 608, 609, the ALJ apportioned 50 percent of the worker's knee injury to nonindustrial causation based on the medical evaluator's opinion that the worker suffered from "'"significant degenerative arthritis."'" The Board stated: "In this case, the issue is whether an apportionment of permanent disability can be made based on the preexisting arthritis in applicant's knees. Under pre-[Senate Bill No.] 899 [(2003–2004 Reg. Sess.)] apportionment law, there would have been a question of whether this would have constituted an impermissible apportionment to pathology or causative factors. [Citations.] Under [Senate Bill No.] 899 [(2003–2004 Reg. Sess.)], however, apportionment now can be based on non-industrial pathology, if it can be demonstrated by substantial medical evidence that the non-industrial pathology has caused permanent disability. [¶] ... [¶] ...

Thus, the preexisting disability may arise from any source—congenital, developmental, pathological, or traumatic." (Id. at pp. 617–619.) We perceive no relevant distinction between allowing apportionment based on a preexisting congenital or pathological condition and allowing apportionment based on a preexisting degenerative condition caused by heredity or genetics.. . . In Acme Steel v. Workers' Comp. Appeals Bd. (2013) 218 Cal.App.4th 1137, 1139 [160 Cal. Rptr. 3d 712], the medical examiner apportioned 40 percent of the worker's hearing loss to "'congenital degeneration'" of the cochlea. (Id. at p. 1139.)

The ALJ nevertheless refused to apportion the disability, and the Board denied the employer's petition for reconsideration. (Id.at pp. 1140–1141.) The Court of Appeal granted the employer's writ of review and remanded the matter to the Board, holding Labor Code sections 4663 and 4664 required apportionment for the nonindustrial cause due to congenital degeneration where substantial medical evidence showed 100 percent of the hearing loss could not be attributed to the industrial cumulative trauma. (Acme Steel, at pp. 1142–1143.) Again, we see no relevant distinction between apportionment for a preexisting disease that is congenital and degenerative, and apportionment for a preexisting degenerative disease caused by heredity or genetics..."

By supplemental report, the QME affirmed that she could state "to a reasonable degree of medical probability that genetics has played a role in Mr. Rice's injury," despite the fact that there is no way to test for genetic factors. To support her opinion apportioning genetic factor, the QME cited to the referenced medical studies. In the end the QME apportioned 49% to the applicants 'personal history including genetic issues'. The WCJ found that the city had carried its burden of showing apportionment as to 49 percent attributable to genetic factors, and this is the determination at issue here. The Board reversed reasoning that "finding causation on applicant's 'genetics' opens the door to apportionment of disability to impermissible immutable factors. … Without proper apportionment to specific identifiable factors, and therefore the Board held that the opinion of the QME was not substantial medical evidence to justify apportioning 49% of applicant's disability to non-industrial factors."

"'Disability' as used in the workers' compensation context includes two elements: "(1) actual incapacity to perform the tasks usually encountered in one's employment and the wage loss resulting therefrom, and (2) physical impairment of the body that may or may not be incapacitating." (Allied Compensation Ins. Co. v. Industrial Acc. Com. (1963) 211 Cal.App.2d 821, 831 [27 Cal. Rptr. 918].) Permanent disability is "'"the irreversible residual of an injury,"'" and permanent disability payments are intended to compensate for physical loss and loss of earning capacity. (Brodie, supra, 40 Cal.4th at p. 1320.) Here, Dr. Blair identified Rice's disability as neck pain and left arm, hand, and shoulder pain, which prevented him from sitting for more than two hours per day, lifting more than 15 pounds, and any vibratory activities such as driving long distances. All of these activities were included in Rice's job description.

Rice's injury, on the other hand, was a cumulative injury, which Dr. Blair stated Rice acknowledged was not an exact or isolated injury, but which he believed was a consequence of repetitive motion primarily resulting from his employment. Thus, the injury was repetitive motion. Dr. Blair did not conclude, as the Board apparently determined, that the repetitive motion (the injury) was caused by genetics. Rather, Dr. Blair properly concluded that Rice's disability, i.e., his debilitating neck, arm, hand, and shoulder pain preventing him from performing his job activities, was caused only partially (17 percent) by his work activities, and was caused primarily (49 percent) by his genetics. Contrary to the Board's opinion, Dr. Blair did not apportion causation to injury rather than disability."

The Court of Appeal reversed the WCAB, holding that disability may be apportioned to a genetic predisposition. In support the Court appeared to focus on whether the QME's report constituted substantial evidence

writing that the report reflected, 'without speculation, that Rice's disability is the result of cervical radiculopathy and cervical degenerative disc disease. Her diagnosis was based on medical history, physical examination, and diagnostic studies that included X-rays and MRI's (magnetic resonance imaging scans). She determined that 49 percent of his condition was caused by heredity, genomics, and other personal history factors. Her conclusion was based on medical studies that were cited in her report, in addition to an adequate medical history and examination. Dr. Blair's combined reports are more than sufficient to meet the standard of substantial medical evidence.' In the end the Court held that apportionment may properly be based on genetics/hereditability, i.e., apportionment based on pathology and asymptomatic prior conditions for which the worker has an inherited predisposition," and that "no relevant distinction between allowing apportionment based on a preexisting congenital/pathological condition and allowing apportionment based on a preexisting degenerative condition caused by heredity or genetics exist. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[1], [2][a], 8.06[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.40[2], [3], 7.41[3].

Editor's Comments: The Rice opinion is correct as to its conclusion, but fatally flawed as to the analysis. Simply put the WCAB was correct that the WCJ had improperly apportioned based on causation of injury not causation of disability. First, the careful reader of the Rice decision will note that the Court incorrectly cited the Kos v. WCAB (2008) 73 CCC 529 for the concept of "lighting up" as a basis for apportionment of disability. The 'lighting up' doctrine is only applicable a causation of injury analysis post SB-899/1/1/15, and not causation of disability. While an industrial injury may 'light up' asystematic pathology to create disability, the concept of 'lighting up' is only relevant to establish industrial injury/causation of injury. It is then up the evaluating physician to apportion between the industrial event, activity, or exposure which 'lit up' the prior non-industrial and pre-existing pathology. The relevance of risk factors, (genetic predisposition in the Rice case), is to support that the pathology was pre-existing and not industrial caused. The Court of Appeal should have started, discussed and ended with the single sentence found in the Discussion, section II section: " Again, we see no relevant distinction between apportionment for a preexisting disease that is congenital and degenerative, and apportionment for a preexisting degenerative disease caused by heredity or genetics."

Hikida v. WCAB, Costco (2nd Appellate District) 12 Cal. App. 5th 1249; 219 Cal. Rptr. 3d 654; 82 Cal. Comp. Cases 679; 2017 Cal. App. LEXIS 572

Applicant developed carpal tunnel after working for over a quarter century with Costco. During May of 2010 the applicant elected to proceed with carpal tunnel surgery. Following, and as a result of the surgery the applicant development CRPS. Applicant had no pre-existing history of CRPS. Although the AME apportioned the carpal tunnel as 10% nonindustrial, he found no apportionment of the CRPS as it was the direct result of the carpal tunnel surgery. The AME found that the applicant was totally disabled entirely due to the CRPS. The WCJ apportioned 10% of the disability to non-industrial causation. Applicant sought reconsideration.

The WCAB, in a split panel decision upheld the WCJ. However, the dissent argued that because the entirety of the total disability was the result of the industrial surgery, apportionment was not proper.

"Under the changes brought by the 2004 amendments, the disability arising from petitioner's carpal tunnel syndrome was apportionable between industrial and nonindustrial causes. However, petitioner's permanent total disability was caused not by her carpal tunnel condition, but by the CARPS resulting from the medical treatment her employer provided. The issue presented is whether an employer is responsible for both the medical treatment and any disability arising directly from unsuccessful medical intervention, without apportionment. For the reasons discussed below, we conclude it is. . . The long-standing rule that employers are responsible for all medical treatment necessitated in any part by an industrial injury, including new injuries resulting from that medical treatment, derived not from those statutes, but from (1) the concern that applying apportionment principles to medical care would delay and potentially prevent an injured employee from getting medical care, and (2) the fundamental proposition that workers' compensation should cover all claims between the employee and employer arising from work-related injuries, leaving no potential for an independent suit for negligence against the employer. Nothing in the 2004 legislation had any impact on the reasoning that has long supported the employer's responsibility to compensate for medical treatment and the consequences of medical treatment without apportionment."

Hikida v. WCAB, Costco (2nd Appellate District) 82 Cal. Comp. Cases at pgs. 685-90.

Editor's Comments: A careful reading of the Hikida decision might limit its application to medical treatment resulting in a "new condition/diagnosis". I believe that an aggravation and worsening of an existing condition/diagnosis due to medical treatment would justify apportionment. In Hikida if the surgery had merely produced a worsening of the PD associated with the carpal tunnel, apportionment would have been appropriate. In Hikida a completely new condition, CRPS, not previously present and solely the result of the surgery rendered the applicant totally disabled.

See also, County of Sac. v. WCAB (Chimeri) 75 CCC 159; Nilsen v. Vista Ford 2012 Cal.Wrk.Comp.P.D. LEXIS 528; Moran v. Dept. of youth Authority 2011 Cal.Wrk.Cop. P.D. Lexis 43; Steinkamp v. City of Concord 2006 Cal.Wrk.Comp. P.D. LEXIS 24

The Court of Appeal reversed the WCAB/WCJ holding that while disability resulting from the carpal tunnel appeared proper, apportionment of compensable consequence injuries may not be proper. Here the applicant developed CRPS as a result of the surgery, not the CT injury. The Court found that "Nothing in the 2004 legislation had any impact on the reasoning that has long supported the employer's responsibility to compensate for medical treatment and the consequences of medical treatment without apportionment.

III. Compromise & Release

Ferragamo vs. St. Louis (Los Angeles) Rams (2017) 45 CWCR 175

A former professional NFL quarterback for the Los Angeles Rams originally pled, in the mid-1980s, a cumulative trauma injury to "multiple body parts, including but not limited to orthopedic, internal and ENT" as a result of his playing career with the Rams and two other NFL teams. This claim was resolved via C&R in 1988 with the standard language of "Employee releases and forever discharges said employer and insurance carrier from all claims and cause of action, whether now known or ascertained, or which hereafter arise or develop as a result of said injury, ... " The applicant was later diagnosed with chronic traumatic encephalopathy (CTE) as a result of repetitive head trauma. Applicant sought recovery for injury to brain due to the same period of CT resolved by the prior CT. Applicant argued that the effects of the CTE were latent and that CTE is an insidious brain disease that neither he, nor the professional football teams had any knowledge of the existence at the time of the original C&R. Thus, Applicant had not released the defendants from the liability for its effects. Defendant asserted that the additional claim of injury of CT injury was resolved by the prior C&R and thus was barred by res judicata because the C&R had the pre- printed language akin to an applicant releasing an employer for all known and unknown cause of action, now and in the future. The WCJ agreed holding that the prior C&R was a "final judgment on the merits," thus preventing applicant from adjudicating any newly-discovered liability issues" against the same defendants.

By split panel the WCAB reversed the WCJ's decision, holding that the res judicata doctrine did not bar applicant's later brain injury claim as neither applicant nor the teams could have known at the time of signing the 1988 C&R that he was suffering from CTE, as the disease was not discovered by medical science until well after the settlement agreement. The Applicant could not have "knowingly" released a condition based upon the non-existence of evidence known to either the medical or legal community. Citing *Casey vs. Proctor* (1963) 59 C2d 97 the WCAB noted that sanctity of contract should be enforced where an injured worker knows or should have known that there was the possibility of further complications occurring from the injury that is claimed. This record and medical evidence proffered at the trial had not supported a conclusion that Ferragamo knew or should have known that he had an undiagnosed brain injury, then without symptoms, and he intended to waive any and all claims related to that unknown condition. Yes, Ferragamo had experienced some mild post-concussion symptoms and occasional headaches but one could not presume to have knowledge of a condition that requires an expert opinion to diagnose and which had not yet entered the medical community. At the time of the first C&R, CTE diagnoses could not have been made even with expert testimony. Citing *Chevron USA vs. WCAB (Steele)* (1990) 219 Cal App 3d 1265, 55 CCC 107 the WCAB wrote that “There can be more than one injury, specific or cumulative, from the same or separate events that give rise to more than one claim.” The WCAB majority also cited and discussed *O'Meara vs. Haiden* (1928) 204 C 354, which held that only an injury that is known at the time of the settlement, even if unknown or unexpected consequences result therefrom," can be released by the parties. The WCAB concluded that the injury itself was unknown to the football player, as CTE was unknown to the medical community at the time of the settlement.

IV. Cumulative Trauma Injury

Roger Bass v State of California, Dept. of Corrections & Rehabilitation 82 Cal Comp Cases 1034, 2017 Cal.Wrk.Comp. P.D. LEXIS 213 (BPD)

Applicant, a correctional officer for over 30 years, sustained a CT injury for the period ending 7/15/14, to heart, neck, low back, right knee, and left foot. Although Applicant continued to work in his normal and customary job without restriction, he received treatment provided by the employer for a number of years to chronic neck, low back, right knee, and left foot pain. Although the parties stipulated that the orthopedic injuries and injury to heart were the result of a single cumulative injury, the defendant's contended that since the disease process for each type of injury was from different causes, there should be two separate awards, one for orthopedic injury, and one for injury to heart. After trial the WCJ held a single CT, and an awarded PD without application of the CVE, merely adding the disability for the orthopedic injury to the disability for the injury to heart.

In upholding the WCJ, the WCAB held that even though there were two different dates of injury under Labor Code § 5412 for applicant's heart and orthopedic injuries, there was a single period of injurious exposure for purposes of

determining liability under Labor Code § 5500.5. Further, that while the date of injury under Labor Code § 5412 has relevance to statute of limitations and perhaps allocation of liability for cumulative injury under Labor Code § 5500.5, it does not determine whether employee sustained one or two cumulative injuries. Here the WCAB held a single period of injurious industrial exposure was responsible for both injury to spine, right knee/left foot, as well as to heart. As to whether the disability should be added or the CVE should be applied, the WCAB held that this was a medical question and because the medical record was silent on the issue the matter was remanded for development of the medical record.

Editor's Comments: The decision of Bass v. State of California, Dept. of Corrections is important for two reasons. First, this is the first reported decision that expressly prohibits the WCJ from deciding whether or not to apply the CVE. In the absence of medical evidence on this issue it appears the WCJ must either apply the CVE or perhaps request further development of the medical record. Second, although separate parts or conditions may be injured, where the injurious period in the same, a single CT injury will be found. Here however, if the defendant had established that the injurious exposure for orthopedic injury was different from that of the injury to heart, the result might have been different.

Apportionment of Liability as between co-defendants again applies the doctrine of "Substantial Evidence" but is a hybred of the elements of "strict legal apportionment" and "Date of CT Injury. Apportionment of liability starts with an analysis to determine the Date of CT injury. Here the focus in on "injurious exposure/activity" and the documented consequence. Here the physician is expected through review of medical records, deposition transcripts, and review of job descriptions, to allocate liability among co-defendant who are either sharing the period of CT or are responsible for successive CT industrial injuries. This analysis is factually dependent and requires the reporting physician to use in equal parts medical knowledge, factual/medical information, and common sense. The primary consideration by the evaluating physician should focus on the physical arduousness of the industrial activity, and/or the intensity of the exposure/stressor in addressing the allocation of liability for the subject injurious exposure/activity period or periods. It is the evaluating physician's analysis that is the most important component to apportionment of liability as between co-defendants.

The first step in the analysis is to determine the date of CT injury: (1) Injurious industrial exposure, (2) Disability and (3) applicant's knowledge or reason to know the existence of a cause and effect relationship.

The second step is: Did the last date of "injurious exposure" occur before or after the "Date of CT Injury". If the "injurious exposure" ended before than the "Date of CTinjury", than liability would be on the carrier on the risk during the year ending with the ending of the "injurious exposure/activity/stressor". If the injurious exposure continued beyond "Date of CT Injury" than liability as between co-defendants would be the year period ending upon "Date of CT Injury".

V. Death Dependency Benefits

Pantus v. Get'er Done Trucking, State Compensation Insurance Fund, 2016 Cal. Wrk. Comp. P.D. LEXIS 619 (BPD)

Decedent employee was killed in a motorcycle accident within course and scope of employment. Decedent's son was passenger on the motorcycles and was severely injured. The issue was whether the decedent's son entitled to lifetime benefits as physically and mentally incapacitated from earning as the result of the accident which killed his father/employee.

The WCAB upheld the WCJ's decision which determined that contrary to defendant's position, Labor Code § 3501(a) supports that a minor is entitled to lifetime benefits, where his or her physical or mental incapacity, are the result and occur from the resulting industrial accident. Decedent's son was held entitled to lifetime benefits pursuant to Labor Code § 4703.5. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 9.05[3][a], [b]; Rassp &.05 Herlick, California Workers' Compensation Law, Ch. 9, § 9.11[3]. Sullivan on Comp, Section 12.19, Special Deaths Benefits for Totally Dependent Minor Children.]

VI. Discovery

See also, Morgan v. National Steel and Shipbuilding Company, PSI, Campbell Industries, Zenith Insurance Company, State Compensation Insurance Fund, California Insurance Guarantee Association, 2017 Cal. Wrk. Comp. P.D. LEXIS 141(BPD) holding ***Defendant not allowed to discover applicant medical records regarding HIV/AIDS where claim alleged that decedent's death was caused by industrial exposure to asbestos; Filing workers' compensation claim does not cause injured worker to sacrifice all privacy rights with respect to medical information; Commissioner Razo, dissenting, opined that medical records regarding decedent's HIV/AIDS status were discoverable, and he would return matter to WCJ to determine how best to protect decedent's privacy rights while permitting defendant to review relevant medical records.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 25.40, 25.43, 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45, Ch. 19, § 19.37. Sullivan on Comp, Section 14.17, Privacy of Employee with HIV/AIDS].***

Cann v. Desert View Auto Auction, Insurance Company of the State of Pennsylvania, 2017 Cal. Wrk. Comp. P.D. LEXIS 214 (BPD)

Applicant sustained industrial injuries to his arm on July 13, 2012, and his spine on September 11, 2012. Defendant filed a "Petition to Compel Applicant's Attendance at Defense Vocational Evaluation" on October 27, 2016 and applicant responded by objecting to the evaluation on November 7, 2016. Applicant agreed to the evaluation but requested a court reporter's presence. The WCJ without testimony or other evidence ordered the applicant to attend defendants Vocational Evaluation but also granted applicant's request that a court reporter be present.

On reconsideration, the WCAB reversed holding that although the WCJ has discretion to decide whether or not to order recording of vocational examinations, such an order requires that evidence be provided establishing good cause to allow recording of vocational evaluation. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.07, 25.40, 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1], Ch. 19, § 19.37.]

Abea v. Parco, Inc. PSI, Administered by ClaimQuest, Inc., 2017 Cal. Wrk. Comp. P.D. LEXIS 302, 82 Cal. Comp. Cases 1415

Applicant claimed CT injury to various parts of body for the period ending 11/14/14. The Application in this matter was filed February 1, 2016. Defendant sent delay notice on February 11, 2017, filed an Answer April 18, 2016, which indicated that injury AOE/COE was denied, and set applicant's deposition. A denial notice was sent by defendant on April 28, 2016. Applicant failed to appear at his deposition set for June 9, 2016 and this forced defendant to file a motion to compel. Applicant did not request a PQME until July 20, 2016, and he appeared late for his deposition on September 8, 2016. Dr. Lee, the PQME, did not issue his report until November 7, 2016, after which defendant timely objected and noticed the doctor's deposition for March 17, 2017. On December 21, 2016, applicant file a DOR requesting an AOE/COE hearing.

". . .In setting this matter for trial, the WCJ apparently agreed with applicant's argument at the Pretrial Conference that this case was ripe for trial because "defendant has already denied the case without need for the discovery at issue." To the extent this position interprets Labor Code section 5402 as placing a limit on defendant's right to discovery once a claim is denied, we disagree. It is well-settled that although the statute's presumption of compensability precludes a defendant from disputing liability for injury with evidence which could have been obtained with the exercise of reasonable diligence within the initial 90-day period, this does not mean that defendant thereafter is permanently prevented from seeking evidence on corollary and related issues. (Napier v. Royal Insurance Co. (1992) 20 Cal. Workers' Comp. Rptr. 124 (writ den.).) In other words, the fact that a defendant denies a claim within 90 days does not mean defendant should be deemed ready to proceed to trial on the issue of injury at the expiration of the 90-day period.

In this case, the fact that defendant denied applicant's claim within the 90-day period does not mean that defendant's right to further discovery ended after denial of the claim. This case involves a relatively complex claim of cumulative trauma to multiple body parts or systems, i.e., applicant's lumbar spine, right knee, bilateral hernia, hypertension, and sleep disorder. It also appears that applicant has not been cooperative with discovery, and defendant timely objected to Dr. Lee's report and noticed his deposition before applicant filed his DOR. Defendant also filed a timely objection to applicant's DOR. Under these circumstances, we conclude the WCJ erred in setting the matter for trial. Defendant should have been allowed some time to complete the depositions of applicant and Dr. Lee, which had already been set before the Pretrial Conference. . ."

Abea v. Parco, Inc. PSI, Administered by ClaimQuest, Inc., 2017 Cal. Wrk. Comp. P.D. LEXIS at pg. 303, 82 Cal. Comp. Cases 141

But see contra, Willis v. The Kroger Company dba Food 4 Less, 2017 Cal. Wrk. Comp. P.D. LEXIS 526 (BPD), where removal was denied where order closing discovery pursuant to Labor Code § 5502(d)(3) was determined that defendant had ample opportunity and failed to obtain additional qualified medical evaluator panels to contest issue of extent of psychiatric and internal permanent disability and failed to timely object under Labor Code § 4062 to opinions of primary and secondary/consulting treating physicians regarding psychiatric and internal parts of body being industrially injured, thereby waiving its objection. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 26.03[4], 26.04[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1], Ch. 19, § 19.37; Sullivan on Comp, Section 15.25, Declaration of Readiness to Proceed.]

At conference on February 8, 2017, applicant requested a trial date. At that point defense objected, on the grounds that they had not completed the discovery necessary before the matter could proceed to trial. Applicant argued that the matter should be set for trial as defendant has already denied the case without need for the discovery at issue.

Following discussion with the parties the case was ordered set for AOE/COE trial, with the trial judge to address any issues regarding the need for further discovery with the trial judge.

The WCAB reversed holding, the fact that a defendant denies a claim within 90 days does not mean defendant should be deemed ready to proceed to trial on the issue of injury at the expiration of the 90-day period.

Ford v. Workers' Comp. Appeals Bd., (Fourth Appellate District) 82 Cal. Comp. Cases 1105, 2017 Cal. App. Unpub. LEXIS 6899.

Applicant was caught on surveillance video acting in a way which established applicant had exaggerated his symptoms and related disability. Specifically, on one of several occasions the applicant was videotaped following medical examination taking off his sling, driving his car and stopping at an appliance store where, using both hands, he lifted a washing machine into the back of the car he was driving. The PTP neurologist, who found some neurological abnormalities, stated applicant did "seem to have complex regional pain syndrome" but noted he was concerned about the fact "the patient seems to be on multiple medications, yet continues to have severe pain." The surveillance video was taken the early part of 2010, disclosed the middle part of 2010, with a re-examination by the AME the later part of 2010. May 10, 2012, Hernandez pled guilty to one count of violating section 1871.4, based on his May 2010 visit to PTP neurologist. He was placed on summary probation and required to pay $9,000 in restitution.

Editor's Comments: It should be highlighted that two facts were critical in the Ford v. WCAB decision. First, the parties were utilizing an AME whose opinion the WCJ relied. Second, the AME conducted a re-examination of the applicant after disclosure of the surveillance video. It was this report after this examination in which the AME noted the applicant's condition had improved and appeared consistent with the surveillance video. The Court in reaching their decision cited and discussed , Tensfeldt v. WCAB (1998) 66 Cal.App.4th 116 [77 Cal. Rptr.2nd 691, and Farmers Ins. v. WCAB (2002) 104 Cal.App.4th 684 [128 Cal.Rptr.2d 353]. The Court wrote, "notwithstanding a conviction for workers' compensation fraud, "entitlement to receive further compensation benefits after a fraud conviction necessarily will require (1) an actual, otherwise compensable, industrial injury; (2) substantial medical evidence supporting an award of compensation not stemming from the fraudulent misrepresentation for which the claimant was convicted; and (3) that claimant's credibility is not so destroyed as to make claimant unbelievable concerning any disputed issue in the underlying compensation case." (Ford v. Workers' Comp. Appeals Bd., (Fourth Appellate District) 82 Cal. Comp. Cases at pg. 1107). Thus, it would appear the succinct holding is that Insurance Code 1871.5 bars only that portion of the benefit secured by the fraudulent misrepresentation, and not those benefits to which the applicant is determined otherwise to be entitled.

During the re-examination in 2010 after disclosure of the videotape, the AME noted improvement, but found disability justifying a 56% WPI based upon a diagnosis of CRPS. The WCJ made a disability awarded of 70%.

In upholding the WCJ, the Court of Appeal held that although the applicant's falsely exaggerated the extent of his disability and pled guilty to insurance fraud, this did not bar applicant's entitlement to a 70% PD award per the AME. The Court held that where the benefits were not "owed or received as a result of a violation of Section 1871.4 for which the recipient of the compensation was convicted, and thus the exaggeration did not affect applicant's actual entitlement to benefits, applicant's entitlement is not barred. See also, Tensfeldt v. WCAB (1998) 66 Cal.App.4th 116 [77 Cal. Rptr.2nd 691; Farmers Ins. v. WCAB (2002) 104 Cal.App.4th 684 [128 Cal.Rptr.2d 353]. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 2.03[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 11, § 11.30[2], [3].]

VII. Lien Claims

Maria De La Luz Garcia v. Morton Manufacturing, 2016 Cal. Wrk. Comp. P.D. LEXIS 480 (BPD)

WCAB rescinded WCJ's finding that lien filed by lien claimant Sepulveda Plaza Medical Center, Inc., on 5/25/2012 for services rendered to applicant between 7/2/2007 and 8/27/2007 was barred by three-year statute of limitations in Labor Code § 4903.5(a), when WCAB found that amendments made to Labor Code § 4903.5 defining statute of limitations for filing liens became effective on 1/1/2013 and does not apply retroactively to liens filed prior to effective date, and that, consequently, WCJ acted without or in excess of her powers in applying three-year statute of limitations to bar lien claimant's lien for reasonable medical expenses incurred on applicant's behalf. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 30.04[8][a], 30.20[1], 30.21; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.111[3], [5].]

". . .Generally, statutes operate prospectively only, and there is a presumption against retroactivity absent "'. . . express language of retroactivity or if other sources provide a clear and unavoidable implication that the Legislature intended retroactive application.' (McClung v. Employment Development Dept. (McClung) (2004) 34 Cal.4th 467, 47 quoting Myers v. Phillip Morris Companies, Inc. (Myers) (2002) 28 Cal.4th 828, 844, emphasis in the original.) It is too well settled to require citation of authority, that in the absence of a clearly expressed intention to the contrary, every statute will be construed so as not to affect pending causes of action. Or, as the rule is generally stated, every statute will be construed to operate prospectively and will not be given a retrospective effect, unless the intention that it should have that effect is clearly expressed. (Collet v. Alioto (1930) 210 Cal. 65, 67.). . ."

Maria De La Luz Garcia v. Morton Manufacturing, 2016 Cal. Wrk. Comp. P.D. LEXIS at pg. 482.

Editor's Comment: The Court in De La Luz Garcia v. Morton Manufacturing also affirmed that a claim on delay pursuant to Labor Code § 5402(c) requires employer to provide applicant with reasonable and necessary medical treatment until claim is either accepted or rejected, and that lien claimant in this situation is not required to establish that applicant's alleged injuries for which treatment was provided were industrial to recover its lien for treatment provided during delay period pursuant to Labor Code § 5402(c). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.07[3][a], 30.25[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4 § 4.03[2], [3].]

See also, McKinney v. Enterprise Rent-A-Car of San Francisco, 2016 Cal. Wrk. Comp. P.D. LEXIS 495 (BPD), which held that Administrative Director Rules 9785(g) and 9792.6.1(t)(2) which requires the RFA to include documentation substantiating the need for the requested treatment, but it is the primary treating physician, and not a claims adjustor, who knows what medical records substantiate the requested treatment. Therefore, the defendant's failure to take the initiative and submit applicant's complete medical record to the UR doctor will not constitute a willful failure to comply with its regulatory and statutory obligations, nor an indication of a bad faith tactic that is frivolous or solely intended to cause delay justifying the impositions of 5813 sanctions. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][f], 22.05[6][b][v], 23.15; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10, Ch. 16, § 16.35[2]. Sullivan on Comp, Section 7.34 Utilization Review – Requests for Authorization]

See also, California Insurance Guarantee Association v. Sylvia Mathews Burwell, Secretary Of Health And Human Services; United States Department Of Health & Human Services; And Center For Medicare & Medicaid Services (United States District Court For The Central District Of California) 227 F. Supp. 3d 1101; 2017 U.S. Dist. LEXIS 1681; 96 Fed. R. Serv. 3d (Callaghan) 793; 82 Cal. Comp. Cases 47, in which CMS held only entitled to that portion of medical treatment provided by CIGA pursuant to an accepted industrial injury, and not that portion of non-industrial treatment despite charges containing diagnosis codes covered and diagnosis codes not covered by workers' compensation insurance policies [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 29.09[2][c], [e], [g]. Sullivan on Comp, Section 3.47, California Insurance Guarantee Association]

See also, Riddle v. Las Flores Convalescent Hospital, CIGA by its servicing facility Intercare Insurance Services, for Ullico Casualty Co., in liquidation, 2017 Cal. Wrk. Comp. P.D. LEXIS 20 (BPD), in which CIGA held not entitled to reimbursement where prior injury settled by C&R before CIGA injury, as defendant for prior injury was no longer liable to applicant for benefits and was not "other insurance" for purposes of relieving CIGA of liability for benefits following applicant's second injury. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 2.84[3][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, § 3.33[3]; Sullivan on Comp, Section 3.47, California Insurance Guarantee Association].

See also, Maya v. All Commercial Industries, State Compensation Insurance Fund, 2017 Cal. Wrk. Comp. P.D. LEXIS 223 (BPD), holding that although attorney has broad discretion in deciding how to conduct discovery, attorney's broad discretion does not automatically allow for issuance of redundant subpoenas requesting documents that were ordered, obtained, and available from by prior counsel. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 30.05; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.72[1]. Sullivan on Comp, 14.64, Defining Medical-Legal Expenses]

Duncan v. Walmart Stores, (Fourth Appellate District) 18 Cal.App.5th 460, 2017 Cal.App.LEXIS 1111.

Applicant fell during the course and scope of her employment with Wal-Mart. Applicant received workers' compensation benefits including TD and medical care paid by defendant/employer. However, the employee/plaintiff failed to seek recovery for lost wages in the third party civil case. When the applicant/plaintiff received a judgement of $355,000 for pain and suffering, past and future medical treatment, but without an award for loss wages, plaintiff contested workers' compensation lien as to TD.

The Court of Appeal held that the workers' compensation lien against third party recovery maybe properly reduced by amount of reasonable attorney fees and costs. However, the employer/workers' compensation carrier is

entitled to recover the amount of TD paid despite the employee mading no attempt to recover those lost wages from the third party citing and explaining LC§ 3856, subd. (b)). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 11.22[6], 11.42[2][a], [b]; Rassp & Herlick, California Workers' Compensation Law, Ch. 12, §§ 12.06[1], 12.08[4], 12.10; Sullivan on Comp, Section 2.39, Subrogation – Civil Suits]

Williams v. First Student (BPD) 45 CWCR 43 (BPD)

Applicant claimed a cumulative trauma injury while working as a school bus driver. The case was dismissed for lack of prosecution in January 2015. Prior to the dismissal, applicant's attorney had issued subpoenas through lien claimant Med- Legal Photocopy from May through November 2011. The matter proceeded to trial with lien claimant presenting invoices with accompanying proofs of service on defendant. Included in the exhibits was an Invoice Explanation & Review letter that summarized and attached all previous billings and that requested payments. Defendants offered no evidence and no objections to the invoice or the letter. The WCJ found essentially for the defendant holding that the subpoenas were unreasonable and unnecessary as those were for the same documents that defendant already subpoenaed before the lien claimant issued the subpoena. The WCJ also denied reimbursement for subpoenas that hadn't been served on the parties in the case, reasoning that applicant is required to first request documents from the entity before subpoenaing them. Lien claimant filed a petition for reconsideration.

In reversing the WCJ, the WCAB first noted that Labor Code § 4622 requires defendants to pay all medical legal expenses for which the employer is liable including any costs and expenses incurred by or on behalf of any party needed for the purpose of proving or disproving a contested claim. (See Cornejo 81 C.C.C. 451 and Martinez 78 C.C.C. 444.

Next, citing the case of Torres 77 C.C.C. 1113, the Board stated that a lien claimant asserting a lien claim has the burden of proving the necessary elements of its claim. Those elements include showing that (1) a contested claim existed that the time expenses were incurred; (2) the incurred expenses were for the purpose of proving or disproving the contested claim; and (3) the expenses were reasonable and necessary at the time they are incurred. (Labor Code §§ 4620 and 4621 and the case of American Psychometric Consultants 60 C.C.C. 559).

Pursuant to Labor Code § 4622 and 37 (e) (1), if the defendant objects to the reasonableness or necessity of the incurred expenses, the defendant must notify the provider and must indicate the reasons for the objection. The Panel also noted that the defendant must make a specific and non-conclusory written objection to the reasonableness of any medical-legal bill within 60 days of receipt. Failure to do so precludes the defendant from raising reasonableness of the medical-legal cost as a defense. In this case, the WCAB noted that all parties agree that the claim was contested and the expenses that were incurred were for the purpose of proving or disproving a contested claim. Pursuant to Rule 10530, it is not necessary that the attorney first seek to obtain copies of the documents by written release before seeking them by subpoena in order for the lien for photocopy services to be valid nor first request copies from defendant. The panel found the record insufficient to support the WCJ's conclusions and findings that the subpoenas were unreasonable and unnecessary at the time they issued. Pursuant to Labor Code § 4621 (a) the reasonableness and necessity for incurring these expenses shall be determined with respect to the time when the expenses were actually incurred. Reversed and Remanded.

VIII. Medical-Legal Procedures

Hernandez v. Ramco Enterprises, PSI, 2016 Cal. Wrk. Comp. P.D. LEXIS 486 (BPD)

Applicant was a farm laborer who suffered multiple industrial injuries to various body parts. Applicant had filed previously four claims on or before 2/9/2015 and was evaluated for those claims by panel qualified medical evaluator Ernest Miller, M.D., on 12/2/2015. Applicant file with his employer on 2/12/16, after his QME examination, a new claim alleging injury occurring on 9/25/2015, prior to the QME examination date. Applicant sought a new QME panel for the new date of injury. The WCJ found for the applicant and allowed the new Panel. Noteworthy was that the original panel was with an orthopedist and that applicant was seeking the new panel in pain specialty.

In upholding the WCJ, the WCAB held that the applicant was allowed a new QME as the date of injury under LC 4062.3(j) and LC 4064(a) is the date the claim form was filed with the employer pursuant to LC 5401 interpreting Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418 (Appeals Board en banc opinion), despite the fact that the new claim form alleged a DOI prior to date of QME examination set on previously filed injuries, but was filed subsequent to date of QME examination. The WCAB rejected defendant's suggestion that applicant had intentionally delayed filing claim for 9/25/2015 injury until after initial evaluation in order to obtain another panel qualified medical evaluator as there was no evidence

See, Portner v. Costco, Liberty Mutual Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 499 (BPD) holding dispute over appropriate qualified medical evaluator specialty must first be submitted to Medical Director as required by 8 Cal. Code Reg. § 31.5(a)(10), and 31.1(b) applicable rules do not permit parties to bypass requirement that qualified medical evaluator specialty disputes "shall be resolved" by Medical Director, and that it was improper for WCJ to issue determination without first directing parties to submit dispute to Medical Director [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[2], [4], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[2], [4], Ch. 19, § 19.37. Sullivan on Comp, Section 14.29, Medical-Legal Process]

See, Garza v. O'Reilly Auto Parts, Corvel, 2017 Cal. Wrk. Comp. P.D. LEXIS 3; 82 Cal. Comp. Cases 424 (BPD) deciding orthopedic panel specialty was correct panel notwithstanding applicant's request for chiropractic panel; Parties' Labor Code § 4062.2, right to designate specialty is not absolute, and Medical Director has authority under 8 Cal. Code Reg. §§ 31and 31.1(b) to issue panel in different specialty if that specialty is more appropriate than specialty designated by requesting party. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[2], [4], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[2], [4], Ch. 19, § 19.37. Sullivan on Comp, Section 14.29, Medical-Legal Process]

See, Feige v. State of California Department of Corrections, 2017 Cal. Wrk. Comp. P.D. LEXIS 10 (BPD), holding applicant entitled to second QME where claimed back injury involved two cases with separate and distinct injuries with different causes, citing Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418 (Appeals Board En Banc opinion); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.11[11], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[11], Ch. 19, § 19.37. Sullivabn on Comp, Section 14.52, Subsequent Evaluations and Additional QME]

See, Ventura v. The Cheesecake Factory, Zurich American Insurance Company, 2014 Cal. Wrk. Comp. P.D. LEXIS 417 (BPD) where matter dropped from calendar despite no objection by Defendant to applicant's DOR as Labor Code § 4061(i), as amended by SB 863, expressly requires evaluation by agreed or qualified medical evaluator before parties can file declaration of readiness to proceed on issue of permanent disability, and no waiver by Defendant because Labor Code § 4061contains no specific time limits for objection to treating physician's permanent disability findings, and defendant acted reasonably and timely in medical legal process.); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], [2], 22.11[7], 26.03[4], 32.06[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[2], Ch. 16, § 16.54[7]. Sullivan on Comp, Section 15.17, Declaration of Readiness to Proceed]

See also, Luisa Lopez v. County of San Joaquin, PSI, administered by Tristar Risk Management2017 Cal. Wrk. Comp. P.D. LEXIS 197, held that applicant entitled to QME/AME re-examination on petition to reopen pursuant Labor Code § 4062.3(k), as the report after re-examination is admissible on existence, prior to end of five-year period, of new and further disability. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.06[1][e], 32.06[1][ff]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[4][ff]. Sullivan on Comp, Section 14.52, Subsequent Evaluation and Additional Qualified Medical Evaluator Panels in Different Specialties]

See also, Yarbrough v. Southern Glazer's Wine and Spirits, 2017 Cal. Wrk. Comp. P.D. LEXIS 508 (BPD), holding Labor Code § 4062.2(f) only precludes withdrawal from agreed medical examiner after agreed medical examiner has conducted evaluation, but does not preclude unilateral withdrawal by party before submitting to evaluation. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[11], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[1], [2], Ch. 16, § 16.54[11], Ch. 19, § 19.37. Sullivan on Comp, Section 14.29, Medical-Legal Process – Represented Employee]

See also, Dorantes v, Dirito Brouthers and Insurance Co. of the West, 2017 Cal. Wrk. Comp. P.D. LEXIS 237 (BPD), holding that although 8 Cal. Code Reg. §38(i) creates guidelines for the timeline for supplemental QME report, the 60 day requirement when read with Labor Code §4062.5 does not mandate replacement QME Panel absent good cause such as that the delay would result in prejudice to the parties, and the issue of whether the QME report was substantial evidence was not grounds for replacement under 8 Cal. Code Reg. §31.5. See also, Garcia v. Child Development, Inc. 2017 Cal.Wrk.Comp.P.D. Lexis 112, Alvarado v. CR&R Inc, 2016 Cal.Wrk.Comp.P.D. LEXIS 112, Corrando v. Aquafine Corp. 2016 Cal.Wrk.Comp.P.D. LEXIS 318 [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.11[4], [6], 22.13; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[6], [14].]

to support defendant's assertion. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 22.11[11]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[11]. Sullivan on Comp, Section 14.52, Subsequent Evaluations and Additional QME Panels in Different Specialties.]

Catlin v. J.C. Penney, Inc., American Home Assurance, 2017 Cal. Wrk. Comp. P.D. LEXIS 106 (BPD)

Editor's Comments: While the holding in Batten puts to rest securing a privately retained medical-legal report not secured pursuant to Labor Code Sections 4060, 4061, 4062, 4062.1 4062.2 for the purpose of establishing injury and entitlement to PD, Catin also puts to rest securing a medical report" for purposes of addressing issues involving medical treatment.

See also, Cortez v. WCAB (2006) 136 Cal.App.4th 596, 71 CCC 155 in which attempts to secure medical-legal opinions under LC sections 4050 and/or 5701 where both held improper and therefore inadmissible on a pre-SB-899 med-legal case and that the only way in which to obtain an admissible med-legal report is pursuant to LC 4062 et. seq.

See also, Ward v. City of Desert Hot Springs (2006) 34 CWCR 266, 71 CCC 1313 (WCAB Significant Panel Decision) where the WCAB upheld the WCJ noting the limiting language contained in LC 4060(c) and 4062.2(a) which provides that medical evaluations "shall be obtained only" by the procedures contained in 4060& 4062.2 without mention of 4064. The WCAB noted the conflict was irreconcilable and therefore the new amended sections must prevail over the older section of 4064. See also, accord, Nunez v. WCAB (Assoluto, Inc) 136 Cal.App. 584; 38 Cal.Rptr. 3d 914; 71 CCC 161; 2006 Cal.App. LEXIS 157.

Applicant sustained injury which was ultimately resolved via C&R with open med. An issue arose over medical treatment with defendant seeking to return the applicant for re-examination to the AME pursuant to LC 4050. The WCJ agreed by minute order.

On removal, the WCAB held that Applicant may not be compelled to attend 4050 consultation re-examination with AME post C&R with open med, as the original purpose of Labor Code § 4050 was subsumed by more specific statutes, including Labor Code §§ 4060, 4061, 4062, and 4610. Labor Code § 4050 cannot circumvent process set forth in these provisions, in the absence of additional issues beyond medical treatment justifying further examination pursuant to including Labor Code §§ 4060, 4061, 4062. The Court provided an excellent discussion and analysis citing Nunez v. Workers ' Comp. Appeals Bd., 136 Cal.App.4th 584 [71 Cal.Comp.Cases 161]; Cortez v. Workers' Compensation Appeals Bd., 136 Cal.App.4th 596 [71 Cal.Comp.Cases 155]; Batten v. Workers' Comp. Appeals Bd. (2015) 241 Cal.App.4th 1009, 1015. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1], 22.07[2][a], 22.11[11], 24.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03, Ch. 16, § 16.54[11], Ch. 19, § 19.37.]

IX. Medical Treatment Including MPN, and UR/IMR

Lambert v. State of California Department of Forestry, SCIF, 2016 Cal. Wrk. Comp. P.D. LEXIS 492 (BPD)

> *"Labor Code section 4604.5(c)(1) sets a 24 visit cap on physical therapy visits "notwithstanding the medical treatment utilization schedule." However, this cap is not applicable to physical therapy visits for "postsurgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27." (Labor Code section 4604.5(c)(3).)*
>
> *Applicant was correct in asserting that since this was a postsurgical treatment request, SCIF's claims adjuster erroneously relied on the 24 visit cap in Labor Code section 4604.5(c)(1) when he denied Dr. McLennan's request.*
>
> *When considering requests for medical treatment for post-surgical knee complaints, the MTUS provides:*
>
> *(d) If surgery is performed in the course of treatment for knee complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply. (Cal. Cod Regs., tit. 8, section 9792.23.6 Emphasis added.)*
>
> *When a treating physician submits a Request for Authorization for medical treatment to a claims adjuster, Labor Code section 4610(e) provides that only a licensed physician "may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve." Thus a reviewing physician, and not a claims adjuster, is required to apply the MTUS when determining the medical necessity of a proposed medical treatment. (Labor Code section 4610(f).)"*
>
> *Lambert v. State of California Department of Forestry, 2016 Cal. Wrk. Comp. P.D. LEXIS at pg. 494*

Applicant sustained an admitted injury to his left knee on February 7, 2015, while employed as a firefighter by California Department of Forestry and Fire Protection. Applicant's PTP performed a surgical repair of the medial meniscus on October 24, 2015. Applicant was provided physical therapy prior and subsequent to his surgery. The parties stipulated that applicant had at least 28 post-operative physical therapy visits. Applicant's PTP submitted an RFA for an additional eight physical therapy visits. Defendant's claims adjuster issued a denial of the request on May 26, 2016, citing the 24 physical therapy visit cap in Labor Code section 4604.5(c)(1). The additional RFA of 8 PT visits was not submitted to UR, rather the adjuster relied on a pre-surgical denial based upon pre-surgical PT totaling 24 visit. Applicant's attorney responded on May 31, 2016, noting that the 24 visit cap on physical therapy cited by defendant's claims adjuster was not applicable to post-surgical physical therapy, and he demanded that defendant immediately authorize the requested treatment. The matter was submitted on this record at an expedited hearing.

> *See, Garcia, v. American Tire Distributors, Broadspire, 2016 Cal. Wrk. Comp. P.D. LEXIS 527 (BPD), where the Board held that an agreement between the parties to resolve a single medical issue through the use of an AME pursuant to LC 4062(b) cannot be used to avoid application of the UR/IMR process pursuant Labor Code §§ 4610 and 4610.5. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11. Sullivan on Comp. Section 7.36, Utilization Review -- Procedure]*
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> *See also, Hogenson v. Volkswagen of America, Insurance Company of the State of Pennsylvania, 2016 Cal. Wrk. Comp. P.D. LEXIS 488 (BPD, holding that RFA from MPN treating physician is subject to UR/IMR process, which is consistent with the legislative goal of assuring that medical treatment is provided by all defendants consistent with uniform evidence-based, peer-reviewed, nationally recognized standards of care; Commissioner Sweeney concurring separately noted two separate statutory tracks to dispute recommendation of MPN treating physician, consisting of UR IMR (employer objects) and second opinion MPN IMR process (applicable when employee objects); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]. Sullivan on Comp, Section 7.55, Medical Provider Network – Dispute Resolution]*
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> *See also, Rivas v. North American Trailer, 2016 Cal. Wrk. Comp. P.D. LEXIS 572 (BPD) holding that Applicant may properly select individual physician not individually listed on employer's MPN where physician's medical group is listed, and MPN medical groups employs services of physicians who do not register individually with MPN; WCAB interpreting Labor Code § 4616(a)(3) and 8 Cal. Code Reg. § 9767.5.1. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[2]. Sullivan on Comp, Section 7.53, Medical Provider Network.]*

The WCJ held that when treating physician submits RFA for medical treatment, the UR Physician, not claims adjuster, is required to apply MTUS to determine medical necessity of proposed treatment, and that since application of MTUS post-surgical guidelines was required to determine whether additional physical therapy visits were medically necessary to treat applicant's injury, it was beyond claims adjuster's authority to apply MTUS to deny treating physician's RFA, and RFA should have been submitted to UR for review by licensed physician. However, Labor Code section 4604.5(c)(1) sets a 24 visit cap on physical therapy visits "notwithstanding the medical treatment utilization schedule." However, this cap is not applicable to physical therapy visits for "postsurgical physical medicine and

postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27." (Labor Code section 4604.5(c)(3).); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§5.02[2][a], [b], 22.05[6][b][i], [ii]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10[6].]

Federal Express Corporation v. WCAB (Paynes) 82 Cal. Comp. Cases 1014, 2017 Cal.Wrk.Comp. LEXIS 91

Applicant sustained a specific injury on 2/25/97 to various parts of body to include bilateral knees. The claim was settled via C&R with open medical treatment with AME Peter Mandel to decide issues regarding reasonableness and necessity for future medical care. In 2015 the PTP reported that Applicant was a candidate for left knee total arthroplasty after she lost weight. Defendant's UR denied the weight loss requested extension, and the UR denial was upheld by IMR. Thereafter Dr. Mandel issued a report indicating that Applicant needed an additional six months of the weight loss program to enable a left knee replacement.

Applicant filed a DOR requesting an expedited hearing on the issue of her entitlement to an extension of the recommended weight loss program, seeking to enforce the C&R stipulation that the parties would utilize AME Dr. Mandel on future issues of treatment. Defendant objected to the DOR, asserting that the requested treatment was denied by UR/IMR, and that the WCAB had no jurisdiction over the medical treatment dispute.

The matter proceeded to a trial, with the WCJ agreeing with Defendant and concluded that he had no jurisdiction to decide the necessity of the weight loss program since Applicant triggered the IMR process by appealing the UR denial. The WCJ stated, however, that, had the IMR appeal not been filed, he may have allowed the weight loss program, based on Dr. Mandel's opinion and the WCAB's holding in *Bertrand v. County of Orange*, 2014 Cal. Wrk. Comp. P.D. LEXIS 342(Appeals Board noteworthy panel decision).

See, Gonzalez v. Imperial County Office of Education, 2016 Cal. Wrk. Comp. P.D. LEXIS 528 (BPD), holding that dismissal without prejudice be rescinded where when medical reports established diagnosis of agoraphobia and panic disorder and applicant was medically unable to appear in court; Due process required accommodations such as being permitted to appear telephonically or via Skype [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 26.01[3][b], 26.04[1][c]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.07[2][b]. Sullivan on Comp, Section 15.37, Requirement to Appear at Hearing.]

See, Williams v. Department of Corrections & Rehabilitation, 2016 Cal. Wrk. Comp. P.D. LEXIS 511(BPD) holding that it was error for WCJ to order former counsel to attend hearing as witness rather than by subpoena pursuant to Cal. Code Civ. Proc. § 1985, and the subpoena must be personally served as required by Cal. Code Civ. Proc. § 1987. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 25.10[2][a], 26.03[4], 26.05[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1], Ch. 16, § 16.48[1], Ch. 19, § 19.37. Sullivan on Comp, Section 15.47, Trial – Proceedings and Submission]

See, Bonilla v. San Diego Personnel and Employment dba Good People Employment Services, 2017 Cal. Wrk. Comp. P.D. LEXIS 56 (BPD), holding that treatment requests from all physicians, even those treating within MPN, must go through UR/independent medical review (IMR) process mandated by Labor Code § 4610 et seq., and that existing law requires RFAs for medical treatment be utilized by MPN physicians and are subject to all UR requirements.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]; Sullivan on Comp, Section 7.34, Utilization Review – Requests for Authorization.] See also, Parrent v. Workers' Compensation Appeals Board, Pacific Bell Telephone Co. SBC, 82 Cal. Comp. Cases 155; 2017 Cal. Wrk. Comp. LEXIS 3 (Writ Denied), holding that treatment recommendations of medical provider network treating physician, may only be disputed through utilization review/independent medical review process; Commissioner Sweeney, concurring, wrote separately to emphasize that, even if employer raises dispute with medical provider network treating physician's recommendation and submits issue to utilization review, injured worker may, at same time, exercise his or her right to initiate second opinion process provided in Labor Code § 4616.3 or change treating physicians within medical provider network.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]. Sullivan on Comp, Section 7.55, MPN -- Dispute Resolution]

See also, Ramirez v. Workers' Comp. Appeals Bd., 10 Cal. App. 5th 205, 215 Cal.Rptr.3d 723, 82 Cal.Comp.Cases 327, 2017 Cal.App. LEXIS 282, holding that the WCAB has no jurisdiction over whether utilization review and independent medical review had used correct standard, where IMR reviewer arguable corrected but upheld UR basis for denial of further RFA for additional acupuncture treatments holding that whether utilization reviewer correctly followed medical treatment utilization schedule is question directly related to medical necessity and, therefore, is reviewable only by independent medical review; Court of Appeal also held that independent medical review does not violate state separation of powers or due process and does not violate federal procedural due process citing and following Stevens v. WCAB (2015) 241 Cal.App.4th 1074 [194 Cal.Rptr. 3d 469; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.02[1], [2][a]-[d]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11.]

See also, Mata v. Supermercado Mi Tierra, 2017 Cal. Wrk. Comp. P.D. LEXIS 166 (BPD), holding that Applicant was entitled to UR approved treatment where defendant failed to act timely within five-day timeframe in 8 Cal. Code Reg. 9792.9.1(b)(1) to defer liability for recommended treatment, and where defendant decided to proceed with UR rather than defer, it cannot later decide to delay medical treatment approved by UR on basis that it is disputing industrial injury; Since defendant ultimately in this case accepted liability for applicant's neck injury and recommended surgery was certified by UR there was no basis for defendant's failure to authorize surgery.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11.]

On reconsideration the WCAB reversed holding that the 2003 agreement within C&R to utilize AME on issues of future medical treatment was enforceable despite statutory changes implementing utilization review/independent medical review citing *Bertrand v. County of Orange*, 2014 Cal. Wrk. Comp. P.D. LEXIS 342 (Appeals Board noteworthy panel decision). The WCAB also seemed to allow in this limited situation the applicant to proceed both as the to UR/IMR procedures and pursuant to the Stipulation within the C&R. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11.]

X. Procedure

Fassett v. Bruce K. Hall Construction, 2017 Cal. Wrk. Comp. P.D. LEXIS 9 (BPD)

Applicant sustained an industrial injury to multiple parts of body resulting from a MVA occurring on July 28, 2008. Applicant received a net civil settlement from the third-part defendant of $271,558.58. In Pro Per Applicant objected to Defendant's seeking credit. In opposition to defendants request for credit applicant argued (1) that defendant had committed workers' compensation fraud in initially denying his workers' compensation claim and that multiple acts of defendant caused applicant to obtain a reduced judgment from the civil claim; (2) that defendant conducted a sub-rosa investigation and refused to disclose the results of said investigation; (3) that defendant failed to provide certain documents to applicant upon request, which caused applicant detriment in connection with a home mortgage modification; (4) that defendant failed to comply with its regulatory duty to provide relevant medical information to the agreed medical evaluator (AME), which caused inaccuracies in the AME's report, which was placed in evidence in applicant's civil trial, which resulted in a reduced judgment, in that the AME opined that applicant was not a candidate for surgery, when in fact applicant was a surgical candidate and actually underwent surgery following the civil judgment. On April 23, 2013, applicant filed a petition for penalties reasserting the allegations in his objection to credit. Defendant denies applicant's allegations.

See, Gonzalez v. Imperial County Office of Education, 2016 Cal. Wrk. Comp. P.D. LEXIS 528 (BPD), holding that dismissal without prejudice be rescinded where when medical reports established diagnosis of agoraphobia and panic disorder and applicant was medically unable to appear in court; Due process required accommodations such as being permitted to appear telephonically or via Skype [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 26.01[3][b], 26.04[1][c]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.07[2][b]. Sullivan on Comp, Section 15.37, Requirement to Appear at Hearing.]

See, Williams v. Department of Corrections & Rehabilitation, 2016 Cal. Wrk. Comp. P.D. LEXIS 511(BPD) holding that it was error for WCJ to order former counsel to attend hearing as witness rather than by subpoena pursuant to Cal. Code Civ. Proc. § 1985, and the subpoena must be personally served as required by Cal. Code Civ. Proc. § 1987. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 25.10[2][a], 26.03[4], 26.05[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1], Ch. 16, § 16.48[1], Ch. 19, § 19.37. Sullivan on Comp, Section 15.47, Trial – Proceedings and Submission]

See, Alvirde v. Barrett Business Services, 2017 Cal. Wrk. Comp. P.D. LEXIS 5 (BPD), holding that the WCJ cannot compel parties to settle their dispute in particular way, nor can defendant's due process right to trial be made contingent on obtaining job analysis. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 21.02[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 13, § 13.01[2]. Sullivan on Comp, 14.74, Resolution by C&R]

See also, Thompkins v. Citizens Telecom, Continental Insurance Company, 2017 Cal.Wrk.Comp.P.D. LEXIS 300, holding that the "Good cause" standard does not apply to requests to withdraw from representation, and that attorney may withdraw from case as long as withdrawal does not cause prejudice to client's case, even absent good cause, and withdrawal not at a critical stage with proper notice to applicant causes no prejudice to client's case. See also, Ramirez v. Sturdevant (1994) 21 Cal.App.4th 904; Code Civ.Proc., § 284. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 20.01[3], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.04[6], Ch. 19, § 19.37.]

See also, Vargas v. Becker Construction and Ace Private Risk(decision after reconsideration) (August 2017) 45 CWCR 182, 82 C.C.C 182 where a deported applicant was allowed to testify by "FaceTime" (cell phone) where the applicant's identity can be authenticated.

See also, Southern Ins. Co. v. Workers' Comp. Appeals Bd., 11 Cal. App. 5th 961, 217 Cal.Rptr. 3d 898, 82 Cal.Comp.Cases 448, 2017 Cal.App. LEXIS 457, holding that a policy of workers' compensation insurance may be rescinded (Insurance Code 650) effective retroactively based on fraud under Civ. Code 1691, by giving notice of rescission and restoring, or offering to restore, everything of value received under the contract and any party to the contract may seek legal or equitable relief based upon the rescission pursuant to Civ. Code 1692. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 2.61[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, § 3.24[2].]

Applicant filed a DOR for expedited hearing on the issues of temporary disability and medical treatment on August 26, 2016. At expedited hearing the matter was continued to October 20, 2016, with the WCJ writing on the

minutes of hearing: "Discovery is closed. Record open for 15 days for [applicant] to provide RFA & related docs & info from [defendant] RE: trial testimony."

Thereafter, Defendant submitted a request to take the trial off calendar on October 14, 2016, and stated that it had authorized the requested consultation for applicant's right shoulder. Applicant objected to defendant' request to go off calendar on the basis that applicant had already attended a consultation for the right shoulder and wanted medical treatment authorized per the consultant's report. Furthermore, applicant wanted to try the issue of retroactive temporary disability. The WCJ denied the request to take the matter off calendar and instead converted the October 20, 2016 trial date into a status conference.

At the October 20, 2016 status conference the WCJ wrote on the minutes of hearing: "(1) consultation w/ Dr. Simonian RT shoulder - [defense attorney) to advise if apt not scheduled forthwith (2) PQME tentatively to be scheduled w/ Dr. Privite in March. (3) Pet for Removal pending." The WCJ ordered the matter off calendar.

Applicant petitioned for removal of the order taking this matter off calendar. The WCJ issued a Report and Recommendation writing, "Defendant has filed an Answer which the undersigned adopts in its entirety and incorporates herein except for the paragraph on page 5 of Defendant's Answer." Although the WCJ adopted and incorporated defendant's answer into the Report and Recommendation, there was no record or evidence supporting any of the statements made by defendant in its answer.

On removal, the WCAB held that a WCJ may be disqualified for bias pursuant to Labor Code § 5311, Code of Civil Procedure § 641 and 8 Cal. Code Reg. § 10452, where as here the WCJ (1) without hearing testimony or receiving evidence on issues raised by parties granted defendant's petition for credit, and (2) used language suggesting bias against applicant including that applicant was vexatious litigant and that applicant's allegations were "nearly incomprehensible", both without supporting evidence and determined to be factually untrue and improperly dismissive of claims made. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][b][iii], 26.03[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 1, § 1.09[3], Ch. 16, § 16.08[2]. Sullivan on Comp, Section 15.54, Disqualification and Reassignment of Judge.]

"Code of Civil Procedure Section 641 states, in pertinent part:

A party may object to the appointment of any person as referee, on one or more of the following grounds:
(f) Having formed or expressed an unqualified opinion or belief as to the merits of the action.
(g) The existence of a state of mind in the potential referee evincing enmity against or bias toward either party.

WCAB Rule 10452 Provides, "Proceedings to disqualify a workers' compensation judge under Labor Code Section 5311 shall be initiated by the filing of a petition for disqualification supported by an affidavit or declaration under penalty of perjury stating in detail facts establishing grounds for disqualification of the workers' compensation judge to whom a case or proceeding has been assigned. If the workers' compensation judge assigned to hear the matter and the grounds for disqualification are known, the petition for disqualification shall be filed not more than 10 days after service of notice of hearing. In no event shall any such petition be allowed after the swearing of the first witness.
A petition for disqualification shall be referred to and determined by a panel of three commissioners of the Appeals Board in the same manner as a petition for reconsideration.

Labor Code section 5313 requires a WCJ to state the "reasons or grounds upon which the determination was made." The WCJ's opinion on decision "enables the parties, and the Board if reconsideration is sought, to ascertain the basis for the decision, and makes the right of seeking reconsideration more meaningful." (Hamilton v. Lockheed Corporation (Hamilton) (2001) 66 Cal.Comp.Cases 473, 476 (Appeals Board en banc), citing Evans v. Workmen's Comp. Appeals Bd. (1968) 68 Cal.2d 753, 755 [33 Cal.Comp.Cases 350, 351].) A decision ***[*14]*** *"must be based on admitted evidence in the record" (Hamilton, supra, at p. 478), and must be supported by substantial evidence. (Lab. Code, §§ 5903, 5952(d); Lamb v. Workmen's Comp. Appeals Bd. (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; Garza v. Workmen's Comp. Appeals Bd. (1970) 3 Cal.3d 312 [35 Cal.Comp.Cases 500]; LeVesque v. Workmen's Comp. Appeals Bd. (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) As required by section 5313 and explained in Hamilton, "the WCJ is charged with the responsibility of referring to the evidence in the opinion on decision, and of clearly designating the evidence that forms the basis of the decision." (Hamilton, supra, at p. 475.) This matter has proceeded to multiple hearings; however, no evidence has been received and no testimony has been offered to support either party's allegations."*

Fassett v. Bruce K. Hall Construction, 2017 Cal. Wrk. Comp. P.D. LEXIS at pg. 12.

See also, Flores v. Epic Management, The Hartford, 2017 Cal. Wrk. Comp. P.D. LEXIS 11 (BPD), holding that neither the Labor Code nor the WCAB Rules permit parties to choose their own judges. (See Lab. Code, §§ 5310, 5311; Cal. Code Regs., tit. 8, §§ 10452 , 10453.); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 21.02[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 13, § 13.01[2]; Sullivan on Comp, Section 15.54, Disqualification and Reassignment of Judge.]

Ly v. County of Fresno (9-15-17) (Fifth Appellate District), 82 Cal Comp Cases 1138; 2017 Cal. App. LEXIS 882.

The three correctional officers filed suit against the County under FEHA and simultaneously pursued a workers' compensation case alleging psychiatric injuries caused by racial and national origin discrimination, harassment and retaliation. The WCAB issued

a take nothing finding that the employer committed no discriminatory action in that the actions of the employer were based on good faith personnel actions.

But see, contra, Jackson v. The City of Sacramento (1991) 117 Cal. App. 3d 596, where the Court of Appeal held that a finding by the WCAB that an injury was industrial and that the injured worker could not return to his or her prior occupation was not res judicata or collateral estoppel in a case involving denied retirement.

Thereafter, the three officers proceeded with their FEHA claims, alleging discrimination with the employer seeking summary judgment arguing that the doctrines of *res judicata* and *collateral estoppel* barred any further action of the FEHA claims.

The plaintiffs argued (1) *Res judicata* did not apply because workers' compensation is the exclusive remedy for industrial injuries and FEHA claims involved different primary rights and the only differences were remedies in both forums and, (2) Collateral estoppel could not apply because the officers were not litigating an industrial injury in the FEHA action. The trial judge granted the motions for summary judgment holding that the doctrine of collateral estoppel applied and barred the claims. The trial judge held that there were identity of issues, parties, facts and law. The court noted that (1) the officers were afforded the opportunity to present evidence and call witnesses and the parties were represented by counsel before the WCAB; (2) The issues litigated were identical; and (3) The WCJ found that the actions of the County were non-discriminatory, in good faith and based upon business necessity.
The appellate court affirmed the motions for summary judgement.

In upholding the trial court, the Court of Appeal noted that where the former decision is final on the merits and the present proceedings involve the same causes of action the second case is barred under the doctrine of *res judicata*, citing *Busick v. WCAB* (1972) 7 Cal. 3d 967, 973-974. In the *Busick* case, the applicant in the workers' compensation case sued the employer after being shot by the employer in a civil action and recovered. The injured employee then sought a workers' compensation recovery. The Supreme Court held, that once a primary right or a single cause of action is litigated that party may not re-litigate the issue in a different tribunal. There is simply one cause of action."
Here, a finding of unlawful discrimination, harassment and retaliation was overcome by the defense that the employer engaged in lawful, good faith, personnel action.

Essentially the Court held that the plaintiffs had one primary right, the right to recover for an injury caused by discrimination, harassment and retaliation in the workplace. The correctional officers had two alternative forums, FEHA action in the Superior Court and the WCAB under *City of Moorpark v. Superiod Court (1998) 18 Cal. 4th 1143*. Since the WCAB issued a final judgement regarding the same cause of action (discrimination) this bars the FEHA action under the doctrine of *res judicata.*

XI. Penalties & Sanctions

Gage v. Workers' Compensation Appeals Board and County Of Sacramento (3RD Appellate District) 6 Cal. App. 5th 1128; 211 Cal. Rptr. 3d 892; 81 Cal. Comp. Cases 1127; 2016 Cal. App. LEXIS 1120

A deputy sheriff who had sustained a job-related injury and had applied for industrial disability retirement sought penalties under Labor Code 5814 for the county's unreasonable delay in payment of her advance disability pension payments under LC 4850.4. The WCJ ruled LC 5814 penalties were available for the unreasonable delay, but deferred the decision on whether the delay in the deputy's case was unreasonable. The county petitioned for removal. The Workers' Compensation Appeals Board reversed the workers' compensation judge's findings of fact and order.

The Court of Appeal annulled the appeals board's decision and remanded the matter to the board. The court held that the appeals board has jurisdiction to impose penalties under LC 5814, for the unreasonable delay or denial of advance disability pension payments, available under LC 4850.4, to local peace officers who are disabled on the job, because such payments qualify as compensation under LC 3207, because 5814 penalties are available for unreasonable delay or denial of the payment of compensation, and because no other provision of the California Labor Code evinces a legislative intent to exclude such payments from the penalty provisions of 5814. In the instant case, the appeals board had not addressed the plain language of LC 3207 defining compensation, had failed to identify any statute that showed a legislative intent not to follow this plain language in this circumstance, and had failed to recognize its own prior (but more recent) decisions. [See generally, Hanna, Cal. Law of Employee Injuries and Workers' Compensation Law (2016) ch. 10, § 10.40; Cal. Forms of Pleading and Practice (2016) ch. 577, Workers' Compensation, § 577.243. Sullivan on Comp, Section 13.21, Unreasonable Delay]

McFarland v. Redlands Unified School District, 2017 Cal. Wrk. Comp. P.D. LEXIS 495 (BPD)

Applicant contends that defendant's unreasonable delay in providing applicant with the section 4658.7 voucher caused delay in applicant's submission of a claim for section 139.48 supplemental payments, and that supports the imposition of a penalty pursuant to section 5814. The WCJ denied applicant's LC 5814 petition for penalties.

> "**. . .**section 139.48 provides for *"supplemental* payments to workers whose permanent disability benefits are disproportionately low in comparison to their earnings loss." (Italics added.) Section 139.48 supplemental payments are not the liability of the injured worker's employer, but are made from a fund administered by the AD. For these reasons, section 139.48 supplemental payments are not "compensation" under Division 4 of the Labor Code as defined by section 3207 and are not "compensation" as that word is used in section 5814(a) as construed in *Gage*."
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> *McFarland v. Redlands Unified School District, 2017 Cal. Wrk. Comp. P.D. LEXIS at pg. 496.*

On reconsideration, the WCAB upheld the WCJ holding that the Applicant was not entitled to Labor Code § 5814 penalty for delay in providing Labor Code § 4658.7 supplemental job displacement voucher which alledgedly resulted in applicant's delayed application for Labor Code § 139.48 return-to-work supplemental payment. The WCAB held that Labor Code § 139.48 supplemental payments held not employer's liability but are made from fund administered by Administrative Director and, therefore, are not compensation subject to penalty as defined by Labor Code § 3207 or within meaning of Labor Code § 5814(a). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 10.40[1], [3], 27.12[2][c]; Rassp & Herlick, California Workers' Compensation Law, Ch. 11, § 11.11[1]-[3].]

XII. Permanent Disability

Truesdell v. Von's Grocery Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 102 (BPD)

Applicant filed three Applications for Adjudication of Claim (Applications) alleging both specific and CT industrial injuries to psyche, right foot and right ankle, bilateral lower extremities, the psyche, hip, hypertension and GERD, cervical spine, thoracic spine, lumbar spine, right foot, right ankle, sleep disorder, bilateral lower extremities, head, headaches, both legs, both feet, both ankles, psyche, internal systems, stomach, hypertension and bilateral upper extremities.

> *But see, also, Singh v. State of California, Legally Uninsured, 2017 Cal. Wrk. Comp. P.D. LEXIS 204 (BPD), where the opinion of VR expert does not constitute substantial evidence where VR expert failed to address whether permanent total disability was solely caused by industrial injury, or in part by non-industrial causation; Labor Code § 4663 and Benson v. W.C.A.B. (2009) 170 Cal. App. 4th 1535, 89 Cal. Rptr. 3d 166, 74 Cal. Comp. Cases 113, which requires that applicant's permanent total disability be apportioned among his various industrial injuries is applicable to VR opinions where multiple and successive injuries exist; The Combined Values Chart is reserved for combining disability caused by a single injury. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4][a], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA Guides and California Workers' Compensation, Ch. 8.]*

Defendant accepted applicant's claim of cumulative injury to the back and both feet, paid periods of temporary disability indemnity, and provided some medical treatment. Brian S. Grossman, M.D., evaluated applicant on February 14, 2013, and issued a report dated March 28, 2013 in which he recommends a "lateral interbody fusion of all accessible discs from Ll-L2 to L4-L5, followed by multilevel posterior laminectomy and instrumented spinal fusion with pedicle screw instrumentation extending from LI through the sacrum.

On January 23, 2014, applicant underwent the multi-level fusion as recommended by Dr. Grossman. Unfortunately, the surgery was not successful. In a report dated January 6, 2015, Philip A. Sobol, M.D., applicant's treating physician, states that the surgery "has resulted in a failed back surgical syndrome." Dr. Sobol opines that applicant's combined orthopedic, psychiatric, internal and sleep disorders have rendered him unable to return to a gainful employment in the open labor market. (*Id.*, at p. 22.) Dr. Richard Scheinberg, then became applicant's treating doctor. In his report dated March 18, 2015, Dr. Scheinberg states his belief that "this patient is essentially permanent and stationary and is totally disabled and precluded from gainful employment in the open labor market."

Dr. Angerman evaluated applicant on March 3, 2016, and issued report, stating that applicant has reached maximum medical improvement with regard to his spinal injuries and the injury to his right foot and ankle. That after a comprehensive reviews the diagnostic studies, with subjective and objective findings, noted chronic L5-S1 radiculopathy on the left, a fusion of the lumbar and lumbosacral vertebrae from L2-S1 to L6-S1, three broken screws at SI, and clinical findings of tenderness and rigidity in the diffuse lumbar spine, decreased range of motion due to pain, and ambulation with antalgic gait. He then provides a standard whole person impairment rating of 67% WPI. However, Dr. Angerman opines, "from an orthopedic standpoint, …based on the information currently available to me including his

clinical findings in this office as well as his medication intake as described to me, it is felt that the patient would be considered 100% permanently disabled and would be unable to compete in the open labor market." Dr. Angerman confirmed this opinion through supplemental report after review of additional records and also at deposition. At depositon, Dr. Angerman added that "even after apportionment to degenerative changes, as a result of his low back surgeries and the medications he must take to alleviate pain." Based on the opinion of Dr. Angerman, the WCJ after Trial found for the applicant and awarded total disability.

On reconsideration Defendant argued that the Finding and Award was not supported by substantial evidence as it was improper for the AME to address whether the applicant was "precluded from gainful employment in the open labor market". Defendant argued that the issue of "preclusion from the open labor market" should be address by a vocational expert.

The WCAB upheld the WCJ holding that the 100 percent permanent disability "in accordance with the fact" under Labor Code § 4662(b) based upon AME due to combination of failed back surgery/strong pain medications constituted substantial medical evidence without the need for VR expert; Orthopedic AME may properly assess that from medical standpoint that applicant was unable to compete in labor market. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4], 32.02[2], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA Guides and California Workers' Compensation, Chs. 3, 4, 5, 8.].

Torres v. Greenbrae Management/SCIF (July 2017) 45 CWCR 152 (Writ Den.)

Applicant, a tree trimmer fell 20 feet landing on his head. Applicant claimed injury to various parts of body including injury to psyche as a compensable consequence. Applicant also sought compensation under the Guzman Doctrine for sexual and sleep disorder contrary to LC 4660.1.

The WCJ ruled that the psychiatric disability was excluded by the 2013 enactment of LC 4660.1 which excluded psychiatric injuries as a compensable consequence of a work injury.

The applicant petitioned for reconsideration arguing that: (1) the psychiatric injury was a "direct result of the injury", (2) the injury was a "violent act" exception and (3) the injury was "catastrophic" as exceptions to § 4660.1. The applicant also argued that § 4660.1 did not apply where the PD increase involving sleep and sexual disorders where it is assessed pursuant to *Almaraz/Guzman* Doctrine.

The WCAB held that the injury was a "direct cause" of the disability and therefore the "violent act" exception under § 4660.1(c) (2) (A) applied. The panel cited *Larsen v. Securitas Security Services* (2016) 44 CWCR 111 and *Madson v. Michael J. Covaletto Ranches* (Zenith Ins. Co.) (2017) 45 CWCR 65 observing that the fall from the tree and the resulting psychiatric disability, post- traumatic stress syndrome, was a "direct" cause of the injury and not a compensable consequence. Further, the panel held that the "*violent act*" exception applied because the accident was (1) characterized by a strong physical force; (2) characterized by extreme or intense force, or (3) vehemently or passionately threatening. The panel observed that all three exceptions applied to this accident. The panel never addressed whether the injury was a "catastrophic injury" because the "violent act" exception applied and made the claim compensable.

The panel also held that § 4660.1 prohibited the add-on of sleep and sexual dysfunctions to ratings. The panel found that it was a legislative intent, to exclude sleep and sexual dysfunction as an add-ons. To allow add-ons under *Almaraz/Guzman* analysis would circumvent the intent of § 4660.1. The panel also noted that the sleep and sexual dysfunctions are incorporated into the activities of daily living (ADL) under calculation at *Table 1-2* of the AMA Guides. To allow sleep and sexual disorder add-on would duplicate the rating for the same condition.

See also, accord Madson v. Cavaletto Ranches 45 CWCR 65 involving truck roll over pining applicant upside down held "violent act" citing Larson v. Securitas Security 44 CWCR 111.

CompWest Insurance Company v WCAB (Gonzales) (2nd Appellate District) 82 Cal Comp Cases 897, 2017 Cal.Wrk.Comp. LEXIS 54 (WD)

Applicant suffered what appeared to be a catastrophic industrial injury which resulted in a DEU rating of the

Editor's Comments: A claim under Ogilvie is very difficult to establish for three reasons: The Doctrine of Substantial Evidence, the Doctrine of Direct Causation, and that applicant not be Amenable to Rehabilitation pursuant to Contra Costa County v. WCAB (Dahl) (2015 First District Court of Appeals) 240 Cal.App. 4th 746, 80 CCC 1119. Be reminded that it is the applicant who has the burden of proof.

AME's report of 92 percent. However, the WCJ awarded a 100% PD based upon the opinion of the AME, VR expert and the applicant's testimony regarding the applicant's inability to work and lack of amenability to vocational rehabilitation. Defendant sought reconsideration.

The WCJ highlighted that he relied on the Applicant's credible testimony regarding his inability to work, along with the medical evidence and the findings of vocational expert Ms. Winn, which together indicated to the WCJ that Applicant suffered a greater loss of earning capacity than reflected in the formal rating, consistent with In *Ogilvie v. City and County of San Francisco* (2011) 197 Cal.App.4th 1262 [76 Cal.Comp.Cases 624]. The WCJ concluded that Applicant was not amenable to rehabilitation or placement in any modified work offered or otherwise. The WCJ noted that applicant VR expert had thoroughly analyzed Applicant's skills and found several occupations within which Applicant could work. Despite the fact that the defendant's VR expert believed that the applicant's disability was in part caused by the applicant's age, education, and inactive work status, the WCJ found the applicant's VR expert more persuasive. The WCJ noted that the Applicants may rebut their disability ratings by evidence providing an individualized assessment of whether industrial factors limit an applicant's ability to benefit from vocational rehabilitation. In making the determination of applicant's inability to benefit from vocational rehabilitation and re-enter the labor market, the WCJ here relied upon the entire record including the medical evidence that establishes applicant's physical limitations preclude him from rehabilitation or performing the modified work offered by his employer. Writ Denied.

XIII. Psychiatric Injury

Xerox Corporation v. WCAB (Schulke)(2nd Appellate District) 82 Cal. Comp. Cases 273, 2017 Cal.Wrk.Comp. LEXIS 13.

Heart attack resulting in death caused by 10% industrial stress held industrial where WCAB reasoned that when stress causes physical injury occurs, that Labor Code § 3208.3 does not apply, that Labor Code § 3208.3 applies only to physical injuries that are solely caused by psychiatric injury as described in County of San Bernardino v. WCAB (McCoy) (2012) 203 Cal.App. 4th 1469, 138 Cal.Rptr. 3d 328, 77 Cal.Comp.Cases 219. Pursuant to McCoy defendant has burden of proof of establishing that applicant's heart attack was caused solely by non-compensable psychiatric injury so as to avoid liability for death benefits.; See also, accord, Wang v. Southern California Edison (2015) 2015 Cal.Wrk.Comp. P.D. LEXIS 511 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 4.02[3], 4.68[1]-[3], 4.69; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, §§ 10.04[1], 10.06[3][d].]

XIV. Statute of Limitations

Garza v. City of Fresno, 2016 Cal.Work Comp. P.D. Lexis 556.

Applicant was involved in a shooting incident September 20, 2005 and at that time the passenger in a vehicle was killed by Applicant and Applicant was struck by a vehicle which dragged him along the pavement causing a laceration to his arm. Applicant filed a DWC 1 which was filed with the employer on September 22, 2005 and the claim was accepted. Applicant was sent to the department's psychologist and after some disability leave returned to work.

> *"...proceedings for the collection of benefits must commence within one year of the date of injury or the last date on which medical benefits were furnished. (Lab. Code, § 5405.) The employee bears the initial burden of notifying the employer of an injury, unless such notice is unnecessary because the employer already knows of the injury or claimed injury from other sources. The employer then bears the burden of informing the worker of his or her possible eligibility for benefits and providing a claim form. (Lab. Code, §§ 5401, 5402; Honeywell v. Workers' Comp. Appeals Bd. (Wagner) (2005) 35 Cal.4th 24 [70 Cal.Comp.Cases 97].) A breach of the duty to provide the* ***[*11]*** *requisite information tolls the statute of limitation for the filing of an application, for so long as the injured employee actually remains unaware of his possible rights. (Reynolds v. Workers' Comp. Appeals Bd. (1974) 12 Cal.3d 726, 730 [39 Cal.Comp.Cases 768].) Moreover, under section 5409, the statute of limitations is an affirmative defense, and thus, it is defendant's burden to show that it has run and that the claim is barred. (Lab. Code, § 5409; Kaiser Foundation Hospitals v. Workers' Comp. Appeals Bd. (Martin) (1985) 39 Cal.3d 57 [50 Cal.Comp.Cases 411].)"*
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> *See also, Bolanos v WCAB (Jimenez) (10/3/2017) 82 Cal Comp Cases 1097, where the applicant filed worker's compensation claim against uninsured employer contractor and not owner of premises where he was working at time of injury, and where applicant knew of the potential liability of an entity other than the named target employer, the statute of limitation was not tolled against the unnamed entity while the issue of employment was being litigated against the named entity.*

A subsequent claim was filed for [cumulative trauma (CT)] injury ending July 29, 2011 which included injury to psyche. This claim has been settled in accord with the medical opinions of Brian Jacks, M.D. In his reports evaluating Applicant, Dr. Jacks opined that Applicant had sustained a psychiatric injury related to the 2005 shooting incident and that he had experienced a suicide equivalent (responding to police calls without backup) and also PTSD resulting in a

psychological splitting maneuver. Because of the symptoms and problems experienced by Applicant particularly related to the suicide equivalent. When Applicant's sergeant learned of this he took Applicant for treatment with psychiatrist Richard Blak, M.D., with the first treatment being in July 2011. Dr. Jacks apportioned some of the psychiatric disability in his reports to the CT claim but also to the September 20, 2005 specific shooting incident.

Thereafter, Applicant filed an Application for Adjudication regarding the September 20, 2005 claim alleging injury to psyche. The Application was filed March 29, 2012, which is within one year of the last provision of medical benefits when the sergeant transported Applicant for interventional treatment with Dr. Blak.

In his Report, the WCJ states that "there is no reliable evidence by anyone with actual knowledge of what was sent to Applicant, that he received correct information and/or the benefits pamphlet." The WCJ thus found for the Applicant that the claim was timely filed within one year of the date of last treatment provided. Further, the settlement of the companion CT ending 2011 left unresolved liability for psychiatric injury involving the 2005 injury.

In upholding the WCJ, the WCAB wrote, "In this case, defendant had knowledge of the psychiatric component of the September 20, 2005 injury. Applicant testified that he was sent by the Department to police psychologist Jana Price-Sharps who told him to take a week off of work. This testimony was corroborated by defendant's adjusting supervisor Ms. Artist who testified that Dr. Price-Sharps' psychological treatment was paid for by the City. Applicant received psychological treatment for the 2005 psychiatric injury in July 2011 when applicant's sergeant learned of psychiatric symptoms applicant was experiencing and physically took him to Dr. Blak. The furnishing of this treatment was within one year of the date that applicant filed the Application alleging injury to body part "842" (referring to "Nervous system—Psychiatric/psych" in the instructions to the form) on March 29, 2012. Therefore, the filing of the Application was timely under section 5405.

XV. Subsequently Injury Benefits

Baker (as SIBTF administrator) v. WCAB (Guerrero), July 28, 2017, 82 Cal Comp Cases 825, 13 Cal. App. 5th 1040, 2017 Cal.App. LEXIS 662.

Applicant, a construction laborer, filed a claim for worker's compensation claim and received TD from 11/18/05-12/4/05 and 1/17/06-6/15/06. His case settled by compromise and release in December 2014. The applicant also applied for SIBTF benefits. The SIBTF contested applicant's entitlement to benefits, and further argued that its obligation should begin when Applicant's injuries became permanent and stationary on January 26, 2011, rather than the last date of payment of TD which occurred on 7/15/06.

> *". . . LC 4650(b)(1) provides that an employer must begin making permanent disability payments to an employee within 14 days of the date that the employee's last payment for temporary disability was owed. Even if the employee's injury has not yet been determined to be permanent and stationary, the employer must start making permanent disability payments once temporary benefits cease. . ."*
>
> *". . . Section 4751 provides, "[i]f an employee who is permanently partially disabled receives a subsequent compensable injury resulting in additional permanent partial disability so that the degree of disability caused by the combination of both disabilities is greater than that which would have resulted from the subsequent injury alone, and the combined effect of the last injury and the previous disability or impairment is a permanent disability equal to 70 percent or more of total, he shall be paid in addition to the compensation due under this code for the permanent partial disability caused by the last injury compensation for the remainder of the combined permanent disability existing after the last injury as provided in this article. . .."*
>
> *Baker (as SIBTF administrator) v. WCAB (Guerrero), July 28, 2017, 82 Cal Comp Cases at pg. 829*

The WCJ founds that Applicant's pre-existing condition which when combined with the subsequent industrial injury left applicant permanently disabled and made an awarded against the SIBTF. The WCJ also found that the SIBTF payments should begin June 16, 2006, the day after temporary disability payments stopped, rather than the day after the applicant became P&S (1/26/11).

On reconsideration, the WCAB upheld the WCJ. On Writ of Review, the Court of Appeal began by discussing the three rules of interpreting workers' compensation statutes noting that (1) "words should first be given their usual and ordinary meanings; (2) that where a statute can have different interpretations, "the interpretation that leads to the most reasonable result should be followed,"; (3) and that "if the statute can reasonably be construed in a manner that would provide coverage or payments [that interpretation] must adopted."

Next, the Court discussed both LC 4650 and 4751 writing that LC 4650(b) provides that an employer must begin PD payments 14 days after the last payment for TD was owed even if the employee is not yet permanent and stationary. LC 4751 provides that an employee entitled to SIBTF benefits, "shall be paid in addition to the compensation

due under this code for the permanent partial disability caused by the last injury compensation for the remainder of the combine permanent disability existing after the last injury as provided in this article..."

A commonsense interpretation, the Court wrote, of the phrase "in addition to" is that the SIBTF must begin payments at the same time the employer is required to begin PD payments. Though this is admittedly subject to different interpretations, the statute does not expressly state when SIBTF benefits should begin. The Court must use the construction that leads to the most reasonable result. Supporting a determination that SIBTF benefits should begin with last payment of TD, the Court noted the change in the law altering the timing for payment of temporary and permanent disability supports its analysis. Specifically, when Section 4656 was amended to cap TD at 104 weeks, the law was also amended to provide that payment of permanent disability was to begin when temporary disability stop preventing a gap in payments to the injured worker. Thus "[a]s a result, the timing for the start of SIBTF benefits, which under section 4751 must be paid 'in addition to' permanent disability benefits, necessarily also changed." Therefore, the commencing at P&S, PD is due at the end of TD. Further, to deny the injured worker benefits during the period from the end of TD and the P&S date would create a gap. Thus, the Court should adopt a construction that provides payment rather than the creation of a gap in payment.

Citing Gonzales v. Workers' Comp. Appeals Bd. (1998) 68 Cal.App.4th 843, 847–848 [63 Cal.Comp.Cases 1477], the WCAB wrote:

"[T]he decision to retire implicates the element of "willingness to work" in the earning capacity calculus, and the primary factual component of the analysis must be whether the worker is retiring for all purposes, or only from the particular employment. (See Van Voorhis v. Workmen's Comp. Appeals Bd. (1974) 37 Cal. App. 3d 81, 90 ["matter of common knowledge" people often work at other jobs after retirement].) If the former, then the worker cannot be said to be willing to work, and earnings capacity would be zero. If the latter, then it would be necessary to determine an earning capacity from all the evidence available. A subsidiary question is whether the decision to retire is a function of the job-related injury. If the injury causes the worker to retire for all purposes or interferes with plans to continue working elsewhere, then the worker cannot be said to be unwilling to work and would have an earning capacity diminished by the injury. Thus, the worker may establish by preponderance of the evidence an intent to pursue other work interrupted by the job-related injury. (§ 3202.5, 5705; cf. [West v. Industrial Acc. Com. (1947) 79 Cal.App.2d 711, 726] [burden on worker to explain reason for periods of unemployment].)"

Finally, we are not persuaded by defendant's reliance upon Moore v. Workers' Comp. Appeals Bd. (2015) 80 Cal.Comp.Cases 299 (writ den.) to support its contention that "the award of temporary disability is improper because there is no evidence that applicant actually suffered a wage loss." Moore is factually distinguishable. In Moore, although applicant's testimony indicated she was reluctant to retire and her retirement letter showed her physical duties also played a role, the rest of the record showed that applicant retired on account of work stress and a work environment she perceived as hostile. In this case, by contrast, applicant liked her work and she wanted to keep working. She wanted to work long enough to obtain full health benefits in retirement. Applicant did keep working for a considerable time after her alleged permanent and stationary date despite significant, ongoing medical symptoms. Applicant's testimony also shows that she struggled to keep working even after the employer provided accommodation, and this continued until the symptoms worsened to the point that she could not continue. Factually, this case is worlds apart from Moore. We will deny defendant's petition for reconsideration.

Castellanos v. County of Kern, County Counsel, 2016 Cal. Wrk. Comp. P.D. LEXIS pgs 634-635.

See also, Guindon v. Robertson's Ready Mix, 2016 Cal. Wrk. Comp. P.D. LEXIS 615 (BPD), holding TD is payable at maximum rate in effect at time temporary disability payments were actually made pursuant to Labor Code § 4661.5, rather at maximum rate in effect when defendant made payments of temporary disability at incorrect rate, interpreting Labor Code § 4661.5 to mean that when any portion of temporary disability payment is made two years or more from date of injury, payment must be computed in accordance with rate in effect at time payment is made, citing Hofmeister v. W.C.A.B. (1984) 156 Cal. App. 3d 848, 203 Cal. Rptr. 100, 49 Cal. Comp. Cases 438.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 7.04[1], [2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, § 6.08[1], [2]. Sullivan on Comp, Section 9.6, Temporary Total Disability after Two Years.]

See also, Henry v. Superior Court of California, San Joaquin County, 2017 Cal. Wrk. Comp. P.D. LEXIS 217 (BPD) holding applicant not entitled to temporary disability indemnity on wage-loss basis after she returned to work for time she spent seeking medical treatment during working hours, as applicant's entitlement to temporary disability ended when she returned to work in full capacity, citing Ward v. Workers' Comp. Appeals Bd.(2004) 69 Cal.Comp.Cases 1179,1182 [writ denied [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 7.01[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, §§ 6.01, 6.10. Sullivan on Comp, Section 7.5, Reasonable Expenses Incident to Treatment.]

XVI. Temporary Disability

Castellanos v. County of Kern, County Counsel, 2016 Cal. Wrk. Comp. P.D. LEXIS 632 (BPD)

Applicant, a medical investigator, sustained CT injury for the period ending February 28, 2013, to her wrists, arms and neck. At hearing, the WCJ found the applicant to be entitled to temporary disability benefits from March 31, 2016 to date and continuing. Defendant sought reconsideration contending that applicant is not entitled to temporary disability benefits because she retired in May 2015 and thereby voluntarily removed herself from the labor force, and that "the award of temporary disability is improper because there is no evidence that applicant actually suffered a wage loss."

The WCAB in upholding the WCJ found that the applicant was entitled to temporary disability benefits for post-retirement period of temporary disability citing Gonzales v. W.C.A.B. (1998) 68 Cal. App. 4th 843, 81 Cal. Rptr. 2d 54, 63 Cal. Comp. Cases 1477,where applicant credibly testified that she retired due to effects of her industrial injury, that defendant presented no legal

authority for its proposition that there must be medical evidence establishing that industrial injury forced applicant to retire, and that defendant's reliance on applicant's post-injury medical treatment and benefit history was overwhelmingly rebutted by applicant's credible testimony regarding her decision to retire.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 7.01[2], 7.02[4][b]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, § 6.01[1]. Sullivan on Comp, Section 9.27, Temporary Disability for Retired Employees.]

Venancio v. White Labs, Inc., Cypress Insurance Company, administered by Berkshire Hathaway, 2017 Cal. Wrk. Comp. P.D. LEXIS 181(BPD)

Applicant, a long-term employee of White Labs, sustained an admitted injury to his neck and back on February 22, 2016. On or about March 15, 2016, agents from the Federal Department of Homeland Security came to the employer's premises and served an Immigration Enforcement Subpoena to produce documents including Forms 1–9. At the same time, the agents served a March 15, 2016 Notice of Inspection to produce documents pertaining to the employment eligibility verification process and Forms 1–9 on March 18, 2016. A March 18, 2016 receipt was provided acknowledging that 101 1–9 forms were received by the Department of Homeland Security.

See also, Romero v. Plantel Nurseries, Inc., AGG Cap Insurance Ltd, 2016 Cal. Wrk. Comp. P.D. LEXIS 672 (BPD) holding an undocumented farm laborer was entitled to temporarily partially disabled during period for which benefits were awarded despite undocumented work status; Entitlement to temporary disability benefits cannot be effected by immigration status, but undocumented applicant may not be provided with more extensive benefits than similarly situated worker who was working in United States legally as doing so would violate constitutional right to equal protection citing Del Taco v. W.C.A.B. (Gutierrez) (2000) 79 Cal. App. 4th 1437, 94 Cal. Rptr. 2d 825, 65 Cal. Comp. Cases 342.); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 3.31, 7.01[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 2, § 2.01[4], Ch. 6, § 6.10. Sullivan on Comp, Section 9.26, Temporary Disability for Terminating Employees].

On April 12, 2016, a Notice of Suspect Documents was served on the employer. Applicant's name was listed as one, whom at that present time, was not authorized to work in the United States. On June 13, 2016, the matter proceeded on the issues of temporary disability claimed from June 13, 2016 to present and continuing, less an attorney's fee.

At trial applicant testified that he resigned because he was worried he was facing potential jail time. There was no evidence that applicant was under duress by the employer when signing the change in relationship form. The defense witness credibly testified that had the applicant not voluntarily terminated his employment and that the applicant would have been offered a modified-duty position. Defendant-employer further testified that he did not know if he could even offer modified work based on the fact that applicant was listed on the April 12, 2016 Notice of Suspect Documents. Applicant never provided any documentation that he was legally allowed to work in the United States, to either the employer or at trial.

The WCJ issued the Findings of Fact and Order that applicant was not entitled to temporary partial disability.

Citing and discussing *Salas v. Sierra Chemical Co*. (2014) 59 Cal. 4th 407, 173 Cal. Rptr. 3d 689, 327 P.3d 797, 79 Cal. Comp. Cases 782, 785, the WCAB upheld the WCJ finding that the applicant was not entitled to temporary disability benefits pursuant to Insurance Code § 1171.5, when applicant was undocumented worker at time of his injury and resigned from his employment because he was worried about potential jail time; Because employer knew applicant was not legally working in United States at time he claimed temporary disability, employer was not required to offer applicant modified or alternative work.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 3.31, 7.01[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 2, § 2.01[4], Ch. 6, § 6.10. Sullivan on Comp, Section 9.26, Temporary Disability for Terminated Employees].

XVII. Third Party Liability

Kesner v. The Superior Court Of Alameda County; Kesner v. Pneumo Abex, LLC; Haver v. BNSF Railway Company, (Supreme Court Of California) 1 Cal. 5th 1132; 384 P.3d 283; 210 Cal. Rptr. 3d 283; 81 Cal. Comp. Cases 1095; 2016 Cal. LEXIS 9431.

This case present the issue of whether an employers or landowners owe a duty of care to prevent secondary exposure to asbestos. Such exposure, sometimes called domestic or take-home exposure, occurs when a worker who is directly exposed to a toxin carries it home on his or her person or clothing, and a household member is in turn exposed through physical proximity or contact with that worker or the worker's clothing. Plaintiff alleges that take-home exposure to asbestos was a contributing cause to the death and that the employer of descendent husband had a duty to prevent this

exposure. Defendants argue that users of asbestos have no duty to prevent nonemployees who have never visited their facilities from being exposed to asbestos used in defendants' business enterprises.

The Supreme Court reversed and remanded holding that in secondary exposure to asbestos cases it is reasonably foreseeable that workers, their clothing, or personal effects will act as vectors carrying asbestos from premises to household members, and employers have a duty under Civ. Code, § 1714, to take reasonable care to prevent this means of transmission. This duty also applies to premises owners, subject to any exceptions and affirmative defenses generally applicable to premises owners; This duty extends only to members of a worker's household because the duty is premised on the foreseeability of both the regularity and intensity of contact that occurs in a worker's home. Kesner v. The Superior Court Of Alameda County (Supreme Court Of California) 1 Cal. 5th 1132; 384 P.3d 283; 210 Cal. Rptr. 3d 283; 81 Cal. Comp. Cases 1095; 2016 Cal. LEXIS 943; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 23.03[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.01[4][c]; Sullivan on Comp, Section 2.30, Civil Claims by Dependents and Other Third Parties.]

CASE LAW UPDATE 2017

The following represents a summary of some of the most recent case decisions issued by the California Supreme Court, California Court of Appeal, and the Workers' Compensation Appeals Board, which the Editor believes will have significance in connection with the practice of Workers' Compensation law. The summaries are only the Editor's interpretation, analysis, and legal opinion, and the reader is encouraged to review the original case decision in its entirety.

Practitioners should proceed with caution when citing to this panel decision and should also verify the subsequent history of the decision. WCAB panel decisions are citable authority, particularly on issues of contemporaneous administrative construction of statutory language [see Griffith v. WCAB (1989) 209 Cal. App. 3d 1260, 1264, fn. 2, 54 Cal. Comp. Cases 145]. However, WCAB panel decisions are not binding precedent, as are en banc decisions, on all other Appeals Board panels and workers' compensation judges [see Gee v. Workers' Comp. Appeals Bd. (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cases 236]. While WCAB panel decisions are not binding, the WCAB will consider these decisions to the extent that it finds their reasoning persuasive [see Guitron v. Santa Fe Extruders (2011) 76 Cal. Comp. Cases 228, fn. 7 (Appeals Board En Banc Opinion)]. Panel Decisions which are designated as "Significant" by the WCAB, while not binding in workers compensation proceedings, are intended to augment the body of binding appellate court and en banc decision and is limited to panel decisions involving (1) issue(s) of general interest to the workers' compensation community, especially a new or recurring issue about which there is little or no published case law; and (2) upon agreement en banc of all commissioners on the significance and importance of the issues presented and resulting decisions. (See Elliot v. WCAB (2010) 182 Cal.App. 4th 355, 361, fn. 3, 75 CCC 81; Larch v. WCAB (1999) 64 CCC 1098, 1099-1100 (writ denied).

I. Injury AOE/COE

Hollie v. Workers' Compensation Appeals Board, Management and Training Corporation, Zurich American Insurance Company, administered by ESIS, (Court of Appeal, 1st Appellate District) 81 Cal. Comp. Cases 368; 2016 Cal. Wrk. Comp. LEXIS 34 (Writ of Review Denied);

Applicant alleged that he suffered an injury to his knee AOE/COE on 4/27/2014 while employed by Defendant as a clinical physician. Applicant contended that he was attending a continuing medical education course at the annual California Society of Anesthesiologists' Conference in San Francisco, that, although he was not required to take that continuing education class, he did need the continuing education credits to maintain his medical license and, therefore, his employment with Defendant. Applicant further alleged that he took the stairs in the conference hotel, rather than take the escalator, that he walked up the stairs two steps at a time, that he stopped in the lobby to pick up some food before proceeding to the lecture hall, and that he dropped the food near the lecture hall, got down to pick it up, and could not stand up. Defendant denies AOE/COE asserting that Defendant employer did not know of, encourage, require participation, or reimburse costs. WCJ found for defendant. Recon denied. See also, *Ezzy v. W.C.A.B.* (1983) 146 Cal. App. 3d 252, 194 Cal. Rptr. 90, 48 Cal. Comp. Cases 611. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.25; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.03[6]; Sullivan On Comp, 5.48, Special Missions – Special Errand]

Editor's Comments: See on the issue of coverage and retroactive cancellation of policy for fraud Berrios v. El Distribution Corp, 2016 Cal.Wrk.Comp. P.D. Lexis 416, where insurance carrier alleged that policy was procured by fraud on misrepresentation that trucking operation was limited to California, and accident occurred during delivery to Tennessee; held that carrier was not allow retroactive cancellation, but employer may seek retroactive rescission/cancellation by way of declaratory relief action in Superior Court, but insurer would be required to provided WC benefits during pendency of declaratory relief action.

xxx Accordingly, the court in Tensfeldt expressly permitted an injured worker to recover benefits, notwithstanding a conviction for workers' compensation fraud. "Entitlement to receive further compensation benefits after a fraud conviction necessarily will require (1) an actual, otherwise compensable, industrial injury; (2) substantial medical evidence supporting an award of compensation not stemming from the fraudulent misrepresentation for which the claimant was convicted; and (3) that claimant's credibility is not so destroyed as to make claimant unbelievable concerning any disputed issue in the underlying compensation case." (Id. at pp. 125–126, italics added.)

Mark Dominguez v. County of Orange, 2016 Cal. Wrk. Comp. P.D. LEXIS 180 (Panel Decision)

Applicant participating in live-in drug rehabilitation program as condition of probation/sentencing was held not to be employee where participation was alternative to additional jail time. The WCAB upheld the decision of the WCJ noting that the defendants did not supervise, control, or remunerate applicant for his work. Further, the defendant Salvation Army is private, nonprofit organization that was acting as "sponsor" to applicant, therefore exempt from employer status pursuant to Labor Code § 3301(b). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 3.02–3.08; Rassp & Herlick, California Workers' Compensation Law, Ch. 2, § 2.02[2].] Sullivan On Comp, chapter 4.3: Employment.

> *Labor Code* ***§ 3301. Exclusions***
>
> *As used in this division, "employer" excludes the following:*
>
> ***(a)*** *Any person while acting solely as the sponsor of a bowling team.*
>
> ***(b)*** *Any private, nonprofit organization while acting solely as the sponsor of a person who, as a condition of sentencing by a superior or municipal court, is performing services for the organization.*
>
> *The exclusions of this section do not exclude any person or organization from the application of this division which is otherwise an employer for the purposes of this division.*

Guerra v. WCAB (Porcini Inc.) (2016 2nd Appellate District) 246 Cal. App. 4th 1301; 201 Cal. Rptr. 3d 623; 81 Cal. Comp. Cases 324; 2016 Cal. App. Lexis 337

Applicant, working as a dishwasher, took the trash from the restaurant to the dumpster located approximately 300 feet away from the restaurant. A patron of the restaurant later found Applicant unresponsive and bloodied in the restaurant's parking lot. Applicant was pronounced dead at the scene by emergency personnel. Applicant was in good health and regularly rode his bike and played soccer. However, the applicant tested negative for tuberculosis at the time of the recent death of his uncle from tuberculosis. The autopsy report concluded that Applicant death was caused by a hemorrhage from an invasive pulmonary aspergillosis as sequelae of treated cavitary tuberculosis.

Dr. Zlotolow, board certified in internal medicine, was retained by Rodas's family to opine on the cause of Rodas's death. Dr. Zlotolow found as follows: "First, the trash bin was full. When the patient opened up the trash bin, he could have been exposed to substantial amount of fumes and odors, which could have caused him to develop a deep cough. When someone has a deep cough, it causes an increased intrathoracic [within the thorax] pressure, which can play a substantial factor in causing an artery in the lung to hemorrhage and bleed. A second factor that could have contributed to the patient's death is the patient performing heavy lifting while taking out the trash, which can also increase the intrathoracic pressure and cause the artery to bleed. In my medical opinion, the reason why the arteries were prone to bleed was due to his non-industrial cavitary lesions brought

> *"'If the disability, although arising from a [preexisting nonindustrial condition], was brought on by any strain or excitement incident to the employment, the industrial liability still exists. Acceleration or aggravation of a pre-existing disease is an injury in the occupation causing such acceleration.'" (California etc. Exchange v. Ind. Acc. Com. (1946) 76 Cal.App.2d 836, 840 [174 P.2d 680].). . .*
>
> *In the case of death occurring at work, the difficulty in proving industrial causation is "no reason to deny an award if the evidence warrants it." (Clemmens v. Workmen's Comp. App. Bd. (1968) 261 Cal.App.2d 1, 7 [68 Cal. Rptr. 804].) All reasonable doubts as to whether an injury is compensable are to be resolved in favor of the employee. (Id. at p. 8.) This is consistent with the mandate that the workers' compensation laws "shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment." (Lab. Code, § 3202.) As aptly stated by the dissent, "Rodas was in the normal course of his duties when he was overcome by sudden, massive pulmonary bleeding. In the absence of any other plausible explanation, it is not medically probable that this event was entirely unrelated to his work."*
>
> *The recent Supreme Court case of South Coast Framing, Inc. v. Workers' Comp. Appeals Bd. (2015) 61 Cal.4th 291 [188 Cal. Rptr. 3d 46, 349 P.3d 141] detailed the less restrictive causation standard in the no fault workers' compensation system. "'In general, for the purposes of the causation requirement in workers' compensation, it is sufficient if the connection between work and the injury be a contributing cause of the injury … .' [Citations.]" (Id. at p. 298.) "A corollary of the no-fault principles of workers' compensation is that 'an employer takes the employee as he finds him at the time of the employment'" and, thus, "'an employee may not be denied compensation merely because his physical condition was such that he sustained a disability which a person of stronger constitution or in better health would not have suffered.' [Citations.]" (Id. at p. 300.) The Supreme Court held that a medical opinion that industrial causation was "'not zero'" was sufficient contribution to award death benefits. (Id. at p. 303.)*
>
> *We therefore find, based on the expert medical testimony of Dr. Zlotolow, that the injury that led to Rodas's death arose out of and in the course of employment. "*
>
> *Guerra v. WCAB (Porcini Inc.) (2016 2nd Appellate District) 81 cal. Comp. Cases at pg. 3331-333.*
>
> *Editor's Comments: Footnote 3 is noteworthy: "We acknowledge respondent's argument that Dr. Zlotolow's report was inadmissible pursuant to Labor Code sections 4060 and 4062.2 and the recent decision in Batten v. Workers' Comp. Appeals Bd. (2015) 241 Cal.App.4th 1009 [194 Cal. Rptr. 3d 511]. Since the argument was not raised in the petition for reconsideration it is therefore waived pursuant to Labor Code section 5904." Unbelievable!! Applicant prevailed because counsel for defendant failed to object to the admissibility of the report of applicant's expert which was improperly obtained.*

on by the tuberculosis. I opine with reasonable medical probability that the cause of his bleed had to do with him taking the trash out, either due to the exposure to garbage waste and/or in combination with him performing heavy isometric lifting while taking out the trash, which both could have played substantial factors in causing the hemorrhage in his lung. The coroner's report stated that the patient was in front of the trash bin when he started bleeding. The patient was predisposed to bleeding due to the lack of natural protection from the cavitary lesions, however in my medical opinion, the exposure to trash fumes and/or the heavy lifting from taking out the trash played substantial factors [to] the hemorrhage in his lungs, which was the cause of death. Therefore at this point in time, I can state with reasonable medical probability that the patient's death is industrial."

The WCJ found injury relying on the opinion of Dr. Zlotolow. The WCAB reversed by split panel decision. However, Commissioner Sweeney dissented holding that the WCJ's application of the "contributing cause" standard was proper. The dissent underscored that the employer takes the employee as he finds him at the time of the employment, and an employee may not be denied compensation merely because his physical condition was such that he sustained a disability, which a person of stronger constitution or in better health would not have suffered. The dissent also found it unreasonable to assume that [applicant's] work played no role in triggering his sudden pulmonary hemorrhaging. The dissent also noted that the appeals board may draw reasonable inferences from the evidence.

The Court of Appeal reversed essentially following the dissenting opinion of Commissioner Margaret Sweeney. The Court held that sufficient factual support by way of circumstantial evidence existed to support physician's inferences as to reasonably medically probable to entitle decedent's survivors to award where death was otherwise "mysterious". Here substantial evidence existed that industrial activity or exposure was a "contributing cause" to the applicant's death. See also, Star Insurance Company v. Workers' Compensation Appeals Board (Maria Rosa Tavares) (6th Appellate District) 81 Cal. Comp. Cases 111; 2016 Cal. App. Unpub. Lexis 409, where evidence was sufficient to show that decedent's physical employment activity contributed to his death. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 4.02[1], [2], 4.03[1], [2], 4.05[2][b]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, §§ 10.01[1]-[4], 10.04[1], 10.05[1]; Sullivan On Comp, 5.58, Injury – Mysterious Death]

II. California Insurance Guarantee Association

California Insurance Guarantee Association v. Sylvia Mathews Burwell; United States Department Of Health & Human Services; And Center For Medicare & Medicaid Services, (United States District Court For The Central District Of California) 2016 U.S. Dist. Lexis 34163; 81 Cal. Comp. Cases 349;

CIGA sought to deny the U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services' claim for reimbursement asserting a state-imposed time limit pursuant to the McCarran-Ferguson Act. That Act provides that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b). CIGA argues that the California Guarantee Act is a state law that "regulates the business of insurance," and thus supersedes any general federal law allowing claims to be filed outside the Guarantee Act's filing deadline. In reply, the United States argues that McCarran-Ferguson does not apply because (1) the Guarantee Act's claims filing statute does not regulate the "business of insurance," and (2) that the Medicare Secondary Payer statute is at any rate a federal statute that specifically regulates the business of insurance.

Apportionment of liability between carriers contained in C&R does not affect joint and several nature of each insurer's liability to third parties, where one carrier subsequently becomes insolvent, the remaining solvent insurer provided "other insurance" within meaning of Insurance Code § 1063.1(c)(9). California Insurance Guarantee Association v. Workers' Compensation Appeals Board (2nd Appellate District) 245 Cal. App. 4TH 1021; 200 Cal. Rptr. 3D 29; 81 Cal. Comp. Cases 317; 2016 Cal. App. Lexis 213, and , accord, Orozco v. Marriott Downtown Los Angeles, 2016 Cal. Wrk. Comp. P.D. LEXIS 189 (Panel Decision); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 2.84[2], [3][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, § 3.33[3]; Sullivan On Comp, 3.47, California Insurance Guarantee Association – Coverage Limitations.]

See also, Prieto v. O.C. Contracting, Inc., American International Group, Inc., UEBTF 2017 Cal. Wrk. Comp. P.D. LEXIS 498 (Split Panel Decision), holding that the UEFTF was not legally obligated under Labor Code § 3715 to reimburse Workers' Compensation Carrier for benefits mistakenly provided to applicant on behalf of illegally uninsured employer because Labor Code § 3715 only contemplates payment of benefits to employees and does not contain any provision that could be construed as allowing payment of UEBTF funds to insurance companies as reimbursement. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 22.13; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, § 3.19. Sullivan on Comp, Section 3.40, UEBTF]

The Court concludes that this issue can and should be resolved on narrower grounds. Specifically, the Court holds that the McCarran-Ferguson Act does not subject the United States to California's claims filing deadline because the Act was never intended to waive the federal government's sovereign immunity, and therefore the claim for reimbursement by the United States for Medicare benefits is not subject to California's claims-filing deadline under McCarran-Ferguson Act because the act was never intended to waive the sovereign immunity of the federal government. Thus, the claim for reimbursement by Medicare was not barred.

III. Discrimination – LC 132(a)

Salazar v. Leprino Foods, 2016 Cal. Wrk. Comp. P.D. LEXIS 213 (Panel Decision)

An employee who suffers retaliation or discrimination under Labor Code § 132a is entitled to increase in workers' compensation benefits, reinstatement and reimbursement for lost wages and work benefits, so as to make employee "whole," which may include a direct payment to applicant for lost pension benefits. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 10.11[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 11, § 11.27[1], [9], [13], [14]; Sullivan On Comp, 11.10, Penalties for Violation of LC 132a.]

IV. Discovery

Weisskopf, v. Chipotle Mexican Grill and Starbucks Coffee Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 61(BPD).

The amended application for adjudication of claim, named both Starbucks Coffee Company and Chipotle Mexican Grill. Chipotle was actually applicant's employer during the final months of the pled cumulative trauma period. The applicant elected against Starbucks under section 5500.5. Applicant and Starbucks selected Dr. Eduardo Lin as their panel qualified medical evaluator (QME), and he examined her and reported August 30, 2012. Dr. Lin performed electromyography and a nerve conduction study, showing neuropathy at the right wrist consistent with carpal tunnel syndrome. He concluded that her condition had resulted from her work for both Starbucks and Chipotle. The case proceeded to trial on January 28, 2013 with the WCJ making a joint and several award of TD and future medical care against defendant with Starbucks to administer. The QME was deposed on January 2, 2013; Chipotle was not invited and did not participate. Chipotle sought to exclude Dr. Lin's reports and "disqualify" him from further involvement in the case, on the basis of the ex parte communication between Starbucks and the QME, which Chipotle contends violated section 4062.3. The WCJ denied petition of Chipotle.

See also, accord, Prajapati v. Vesta Intermediate Funding, Inc., 2016 Cal.Wrk.Comp. P.D. LEXIS 382, rejected co-defendant assertion that applicant's deposition testimony and reports of AME, both obtained before co-defendant became party-defendant, were improperly admitted into evidence in contribution proceeding in violation of due process rights, as at the time AME was selected and depositions obtained had no right to participate in discovery during case-in-chief, and that after case-in-chief was settled and co-defendant was joined as party, co-defendant had ample opportunity to conduct discovery prior to Arbitration; thus no due process violation. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 26.01[2][c], 31.13[2][a], [e]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1][d][v], Ch. 15, § 15.15.]. Prajapati, also holding that the defendant seeking contribution meet burden of proof by producing Compromise and Release agreement, medical record as it exists, deposition of applicant, and proof of payments, than burden shifts to party opposing contribution to raise issues and provide evidence to defeat or reduce contribution entitlement. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 31.13[2][a], [e]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1][d], Ch. 15, § 15.15.]

On reconsideration, the WCAB held that a defendant who is not elected against in a 5500.5 CT claim does not have full discovery rights and has no right to participate in communications with panel qualified medical evaluator until applicant's case-in-chief is resolved and contribution proceedings are initiated. See also, Kelm v. Koret of California (1980) 46 Cal. Comp. Cases 113 (Appeals Board significant panel decision. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 26.01[2][c], 31.13(e); Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1][d][v]; Sullivan On Comp, 5.8, Injury – Contribution Among Defendants].

VI. Lien Claims

Cornejo, v. Younique Café, Inc., Zenith Insurance Company, Western Imaging Services, Inc., Lien Claimant, 81 Cal. Comp. Cases 451; 2016 Cal. Wrk. Comp. LEXIS 48 (En Banc)

Registration and bonding requirements for professional photocopiers (Business & Professions Code §§ 22450 and 22455) do not apply to lien claimant seeking to recover copy service fees as medical-legal expenses under Labor Code § 4620(a) where copy service provided at request of member of California state bar and exemption not limited to photocopiers who are a direct part of attorney's office staff. See also, Cornejo v. Younique Café, Inc. (2015) 81 Cal. Comp. Cases 48 (Appeals Board en banc opinion), Business & Professions Code § 22451(b). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 23.13[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.70[1][c]; Sullivan On Comp, 14.64, Discovery and Settlement –Defining Medical-Legal Expenses]

Baladez v. Coast Plating, 2016 Cal. Wrk. Comp. P.D. LEXIS 11 (Panel Decision)

Failure to calendar lien conference despite having actual notice of its scheduling and having appeared at prior conference, was not a proper basis to reverse WCJ's order of dismissal with prejudice liens for failure to appear at lien conference.. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 30.22[5]; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.114.]

Chorn V. Workers' Compensation Appeals Board (Harris) (2nd Appellate District) 245 Cal. App. 4th 1370; 200 Cal. Rptr. 3d 74; 81 Cal. Comp. Cases 332; 2016 Cal. App. LEXIS 232

Labor Code §§ 4903.05 (Lien Filing Fees) and 4903.8 (Restriction on Assignment of Lien) does not violate any of constitutional provisions nor deprive medical liens holder of state constitutional rights to due process (Cal. Const. art. I, § 7), equal protection (Cal. Const. art. I, § 9), or petition for redress of grievances (Cal. Const. art. I, § 3), and right to contract (Cal. Const. art. I, § 9).. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 30.20[1], 30.25[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.10[4], [5]; Sullivan On Comp, 15.89, Liens – Filing Procedures.]

Ozuna v. Kern County Superintendent of Schools, PSI, 2016 Cal. Wrk. Comp. P.D. LEXIS 98 (Panel Decision)

All copy services provided by lien claimant were provided for purpose of proving or disproving contested claim and, therefore, were reimbursable as medical-legal expenses under Labor Code § 4620(a), and there is no requirement that lien claimant prove that all records copied were specifically relied upon to resolve issue in dispute in order to have valid lien claim for copying records. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 30.05; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.72[1]; Sullivan On Comp, 14.64, Defining Medical-Legal Expenses]

Holder v. Christian dba Adventure Limousine, 2016 Cal. Wrk. Comp. P.D. LEXIS 232 (Panel Decision)

Provider/lien claimant is not required to file request for IBR if employer fails to provide required explanation of review when paying less than amount requested by provider and WCAB then has jurisdiction over this dispute. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][e], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.24, Ch. 17, § 17.70[6]; Sullivan On Comp, 7.67, Submission of Bills and Employer's Response.]. 16, § 16.24, Ch. 17, § 17.70[6]; Sullivan On Comp, 7.67, Submission of Bills and Employer's Response.]

Senguiz v. City of Fremont, York Insurance, 2017 Cal. Wrk. Comp. P.D. LEXIS 522

Dispute regarding payment for treatment provided by lien claimant was subject to Independent Bill Review (IBR) and was not within jurisdiction of WCAB, when defendant objected to lien claimant's bills based on incorrect coding that did not comply with National Correct Coding Initiative (NCCI); that if "the only dispute is the amount of payment and the provider has received a second review that did not resolve the dispute," provider must request IBR within 30 days or bill will be deemed satisfied citing Labor Code § 4603.6(a). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][e], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.24, Ch. 17, § 17.70[6]. Sullivan on Comp, Section 7.69, Independent Bill Review.

Varela v. Morley Group, National Union Fire Insurance Company of Pittsburgh, 2016 Cal. Wrk. Comp. P.D. LEXIS 194 (Panel Decision)

Expert witness cost properly awarded under LC § 5811 where lien claimant had burden of proof to establish all elements necessary to recover on their lien for home care services and testimony was necessary to meet essential element of lien claimants' burden of proof on all issues raised at trial and WCAB reasoned that lien claimants "stood in the shoes" of applicant. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 23.13[2][b], 27.01[8][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.47.]

VI. Medical-Legal Procedures

Gaona, v. Capital Builders Hardware, Southern Insurance Company, Endurance Reinsurance Corporation, 2016 Cal. Wrk. Comp. P.D. LEXIS 148 (BPD)

QME's mandatory deposition policy that deposition fee be received 11 business days in advance of scheduled deposition was inappropriate under Code of Civil Procedure § 2034.450(a) (allowing for payment of deposition fee at commencement of deposition) and 8 Cal. Code Reg. § 35.5(f) (stating that qualified medical evaluators must make themselves available for deposition within 120 days of request), and did not comply with applicable qualified medical evaluator deposition rate of $ 250.00 per hour provided for in Medical Legal Fee Schedule. Chaides, v. The Kroger Company dba Ralphs Grocery Company, PSI, administered by Sedgwick, 2016 Cal. Wrk. Comp. P.D. LEXIS 143 (BPD); See also related, Giron v. Ari Thane Foam Products, 2016 Cal.Wrk.Comp. P.D. 150. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.11[6], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[6], Ch. 19, § 19.37; Sullivan On Comp, 14.64, Discovery and Settlement – Medical-Legal Fee Schedule.]

See also, Sanchez v. Grapevine Catering, Security National Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 136 (Panel Decision) which held that Reg. § 30(d)(1), provides that insurer or employer may request qualified medical evaluator panel during 90 day delay period, but does not preclude applicant from doing so, and that Medical Unit's interpretation otherwise creates conflict between 8 Cal. Code Reg. § 30(d)(1) and Labor Code §§ 4060 and 4062.2.). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.11[1], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[1], Ch. 19, § 19.37; Sullivan On Comp, 14.27, Medical-Legal Procedures on or after 1/1/05]; Also, see Montoya v. Burger Buddies, 2016 Cal. Wrk. Comp. P.D. LEXIS 242 (Panel Decision), and Bahena v. Charles Virzi Construction, 2014 Cal. Wrk. Comp. P.D. LEXIS 638 (Appeals Board noteworthy panel decision), holding panel request during delay period when defendant's delay letter indicated that Labor Code § 4060 evaluation would be necessary to complete its investigation was proper because not allowing would do nothing to streamline the medical evaluation process. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[1], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[1], Ch. 19, § 19.37; Sullivan On Comp. 14.29, Medical-Legal Process.]

Applicant filed two claims of injury alleging multiple body parts including an allegation of injury to psyche as a sequelae to his orthopedic injuries in both the specific and cumulative injury claims.

The parties agreed to use Sherry Mendelson, M.D., as a psychiatric AME. Dr. Mendelson initially evaluated applicant on August 14, 2012. Applicant deposed Dr. Mendelson who recommended that applicant be evaluated by a pain management specialist in order to assist Dr. Mendelson with her reporting. Dr. Mendelson recommended Lawrence Miller, M.D., by name as a potential referral. Applicant then set the appointment with Dr. Miller, which occurred on June 20, 2013, apparently without defendant's agreement. Dr. Miller issued a report on July 15, 2013, which applicant's counsel served upon all parties and the WCAB on July 30, 2013. Without agreement or forewarning applicant served Dr. Miller's report upon Dr. Mendelson at applicant's 11/11/13 reexamination.

At the reevaluation with Dr. Mendelson, applicant hand delivered a copy of Dr. Miller's report along with a cover letter from applicant's counsel. Dr. Mendelson found that applicant was permanently totally disabled on a psychiatric basis. On December 6, 2013, twenty-three (23) days after defendant was notified that Dr. Miller's report was served upon the AME, defendant objected. Ultimately this matter proceeded to MSC on the issue of exclusion of Dr.

Miller's report, but not before the report was provided to the Ortho AME by joint letter from the parties.

On removal, the WCAB upheld the WCJ noting that although Defendant's objected to applicant providing self-procured medical report to Psych AME, objection was waived when defendant agreed to provide report to Ortho AME; WCAB citing Civil Code § 3517, that "Acquiescence in error takes away the right of objecting to it." [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.06[3], 22.11[18]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[4][d], [e]; Sullivan On Comp, 14.41, Discovery and Settlement – Communication with AME/QME].

Objection after receipt and review of late QME report is insufficient to support request for new panel under 8 Cal. Code Reg. § 31.5(a)(12). Kampfen, v. United Parcel Service, Liberty Mutual Insurance, 2016 Cal. Wrk. Comp. P.D. LEXIS 45 (Panel Decision). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.11[4], [6], 22.13, 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[6], [14], Ch. 19, § 19.37; Sullivan On Comp, 14.42, Discovery and Settlement – Timeliness Requirement.]

See also, Loving v. California Department of Corrections and Rehabilitation, 2016 Cal. Wrk. Comp. P.D. LEXIS 238 (Panel Decision) where defendant found to have violated Labor Code § 4062.3 by engaging in ex parte communications with AME regarding criminal workers' compensation insurance fraud investigation, that documents were provided without applicant having opportunity to object, and that defendant's communications were not insignificant or inconsequential, nor does Labor Code § 4062.3 contain exception to ex parte communication rule for criminal investigations. See also, Vaughn v. Central Coast Community Healthcare, 2016 Cal. Wrk. Comp. P.D. LEXIS 217, where documents including consultative rating and other nonmedical evidence sent to QME without being first served on opposition 20 days in advance violated LC 4062.3 and CCR 35. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.06[3], 22.11[18]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[4][d], [e].

Crane, v. State of California, High Desert State Prison, Legally Uninsured, State Compensation Insurance/State Contract Services, Adjusting Agency, 2016 Cal. Wrk. Comp. P.D. LEXIS 179 (BPD)

Applicant claimed psychiatric injury and sought new QME panel on her allegations that Dr. Clegg had sexual bias against her and was incapable of rendering fair and impartial opinion, and that he violated 8 Cal. Code Reg. § 40(2) by failing to advise her that she could terminate evaluation at any time. Of interest was that the WCAB noted in upholding the WCJ, that (1) applicant's assertions of sexual bias were unfounded and constituted "a blatant case of doctor shopping," which is discouraged by WCAB; (2) that absent showing of actual impropriety or bias, failure to advise of right to terminate evaluation does not warrant new qualified medical evaluator panel; that (3) nonetheless the WCAB concluded that Dr. Clegg acted unprofessionally towards applicant by conducting his last medical evaluation of applicant in his home rather than in office setting, forcing applicant to drive several hours and traverse dirty laundry in Dr. Clegg's house, and created appearance of bias by sending all of his reports only to defendant. These circumstances justified issuance of replacement panel notwithstanding that applicant, who was unrepresented at time of her evaluation with Dr. Clegg, did not seek replacement panel until approximately nine months after having received Dr. Clegg's report, especially since contemporaneous treating physician's reports indicated that applicant had complained about Dr. Clegg's conduct even before receiving his report. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.11[6], [15], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[6], [16], Ch. 19, § 19.37; Sullivan On Comp, 14.43, Discovery and Settlement – Disclosure Requirement.

See also, Sandoval v. San Diego Unified School District 2016 Cal. Wrk. Comp. P.D. LEXIS 58 (BPD) holding that a physician requesting authorization for medical treatment are not required to specifically cite to MTUS guidelines where physician has provided care within treatment protocols as stated in MTUS; Commissioner Razo would require that requesting physician's medical reports cite to MTUS in order to comply with Labor Code § 4604.5; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.08[3], 26.06[12][b][ii]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.09[1], [4], [5]; Sullivan On Comp, 7.36, Utilization Review -- Procedure.] But see contra, Thompson v. County of Los Angeles, PSI, 2016 Cal. Wrk. Comp. P.D. LEXIS 107 (BPD) , holding that request for low back surgery in multiple reports based on applicant's complaints of severe low back pain, which correlated to MRI results showing stenosis at L4–5, attached reports concerning lumbar epidural injections and medication, did not justify his recommendation for lumbar surgery by reference to Medical Treatment Utilization Schedule guidelines or address issue of reasonableness and necessity by reference to other elements of hierarchy for evidence-based standards and medical opinion, such as peer-reviewed scientific and medical evidence regarding effectiveness of disputed treatment, nationally recognized professional standards, expert opinion, generally accepted standards of medical practice, and treatments that are likely to provide benefit to patient for condition for which other treatments are not clinically efficacious.

Thompson v. County of Los Angeles, PSI, 2016 Cal. Wrk. Comp. P.D. LEXIS 107 (BPD) also held that defendant's utilization review (UR) non-certification of treating physician's request for spinal surgery was defective as not timely communicated to applicant's attorney pursuant to 8 Cal. Code Reg. § 9792.9.1(e)(3) and was, therefore, invalid, when defendant communicated UR non-certification to applicant's former counsel rather than current counsel even though defendant should have been aware that applicant was being represented by new counsel as defendant was properly served with copy of substitution of attorney over two years earlier and had been served by new counsel with applicant's change of address, and there was no authority supporting defendant's position that service on applicant's former attorney simply because that attorney appeared on outdated official address record satisfied UR notice requirement. See also, accord, Dallas v. Pan Pacific Petroleum, National Union Fire Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 116 (Panel Decision); Relying on, Bodam v. San Bernardino County/Department of Soc. Servs. (2014) 79 Cal. Comp. Cases 1519 (Appeals Board Significant Panel decision) UR decisions defect for failure communicated both by "telephone or facsimile" to requesting physician within 24 hours of decision and communicated to physician and employee/applicant "in writing" within 24 hours.

See also, Lopez v. City and County of San Francisco, 2016 Cal. Wrk. Comp. P.D. LEXIS 206 (Panel Decision)where award of medical treatment recommended by secondary treating physician (surgeon) upheld based on defendant's failure to timely perform utilization review (UR) of requested treatment, rejecting defendant's assertion that RFA may only be submitted by primary treating physician.; See also, accord, KLEIN v. Warner Bros. Studio, 2016 Cal.Wrk.Comp. P.D. LEXIS 236; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10; Sullivan On Comp, 7.34, Utilitization Review.]

See also, Garcia v. Skechers ABHR (Team One) 2016 Cal. Wrk. Comp. P.D. LEXIS 70 (BPD) holding defendant not liable for Non MPN treatment where (1) defendant had valid MPN, (2) prompt care provided by defendant until discharge from treatment without objection, and (3) timely objection by defendant upon learning applicant was treating outside of defendant's MPN. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[3]; Sullivan On Comp, 7.56, Medical Treatment – Medical Provider Network.]

Applicant not entitled to treat outside defendant's MPN as no denial of care where there were over 50 orthopedic surgeons and 15 chiropractors in defendant's MPN within 15 miles of applicant's zip code, despite applicant having contacted 5 doctors all of whom refuse to accept applicant as patient. Arvizu De Guevara v. La Golondrina, Inc., 2016 Cal. Wrk. Comp. P.D. LEXIS 84; 81 Cal. Comp. Cases 472 (Board Panel Decision) Labor Code § 4616(a)(5). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[4]; Sullivan On Comp, 7.36, Medical Treatment – Utilization Review -- Procedures]

Lopez v. California Pizza Kitchen, 2016 Cal. Wrk. Comp. P.D. LEXIS 399

Applicant claimed a slip and fall injury arising out of and in the course of employment to her neck, back, and waist on May 2, 2013. On April 10, 2015, applicant requested the assignment of a panel QME in the field of chiropractic. Applicant's QME panel request stated that the name of the primary treating physician was Lucero, the specialty of the treating physician is Family Practice, and checked the box indicating that a QME panel was being requested for a "§ 4060." Applicant's QME panel request included a copy of defendant's denial letter dated February 2, 2015. (*Id*., p. 1.) Applicant asserts that she also attached a copy *of Tallent v. Infinite Resources (2014) 2014 Cal.Wrk. Comp. P.D. LEXIS 141* (*Tallent* held that Chiropractic medicine constituted substantial evidence) with her QME panel request. QME Panel number 1749465 issued on May 11, 2015 with three chiropractors listed.

§ 31.1. QME Panel Selection Disputes in Represented Cases

(a) Disputes regarding the validity of panel requests shall be resolved by a Workers' Compensation Administrative Law Judge.

(b) Disputes regarding the appropriateness of the specialty designated shall be resolved pursuant to section 31.5(a)(10) of Title 8 of the California Code of Regulations.Either party may appeal the Medical Director's decision as to the appropriateness of the specialty to a Workers' Compensation Administrative Law Judge.

(c) In the event the Medical Director is unable to issue a QME panel in a represented case within thirty (30) calendar days of receiving the request, either party may seek an order from a Workers' Compensation Administrative Law Judge that a QME panel be issued. Any such order shall specify the specialty of the QME panel or the party to be designated to select the specialty.

Upholding Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418 (Appeals Board en banc opinion), Parker v. DSC Logistics, Zurich North America, 2016 Cal. Wrk. Comp. P.D. LEXIS 402; 82 Cal. Comp. Cases 105, (BPD) held that the QME is required to address all medical issues, including dates of injury, holding that the same qualified medical evaluator is required to address all contested medical issues arising from all injuries reported on one or more claim forms filed prior to initial qualified medical evaluation. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 22.11[11]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[11]; Sullivan on Comp, Section 14.52 Subsequent Evaluations and Additional QME Panels in Different Specialties.]

Vera v. Monsanto Company, PSI, adjusted by Sedgwick Claims Management Services, 2016 Cal. Wrk. Comp. P.D. LEXIS 360 (BPD) held that applicant who suffered admitted industrial back injury may obtain additional qualified medical evaluator panels pursuant to 8 Cal. Code Reg. § 32.6, where continuing complaints regarding neurological symptoms and sexual dysfunction outside PTP's expertise, and that although generally parties should obtain opinion of primary treating physician prior to seeking additional qualified medical evaluator panels for different body parts, treating physician's opinion is not mandatory.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 22.11[9]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[9]; Sullivan on Comp, Section 14.52 Subsequent Evaluations and Additional QME Panels in Different Specialties.]

On May 19, 2015, applicant struck one of three listed QMEs, Dr. Sameer M. Ibrahim, D.C., and notified defendants via fax. On May 27, 2015, defendants wrote to applicant's attorney objecting to the validity of the QME list for the alleged failure to comply with Labor Code § 4062.2, asserting that applicant's panel request failed to include the required objection by applicant to a treating doctor's report and discussion of a potential AME. On May 28, 2015, applicant wrote to Dr. Shahin Emrani, D.C., copying defendants, advising Dr. Emrani that defendants failed to strike a doctor on the QME panel within the statutory time period and therefore applicant was requesting an appointment with Dr. Emrani. On May 29, 2015, defendants wrote to applicant's and again voiced an objection to the QME panel, this time on the basis that chiropractic was an inappropriate specialty. Defendants stated that they were nonetheless striking Dr. Emrani. On September 1, 2015, applicant filed a Declaration of Readiness to Proceed in an attempt to compel an examination with Dr. Emrani.

On April 25, 2016, the WCJ issued her decision regarding this dispute, finding that there was a legal basis to strike the QME panel with a chiropractic specialty and to issue a replacement panel in the field of orthopedics. (FF&O, p. 1.) Specifically, the WCJ found that applicant's QME panel request was invalid because it failed to include both a copy of the report of the designated treating physician, Dr. Lucero, and a written objection letter identifying the necessity of a compensability examination as required by Rule 30(b) (Cal. Code Regs., tit. 8, § 30(b)). The WCJ also noted her belief that the QME panel was invalid because "the panel was requested in the specialty of chiropractic medicine although Dr. Lucero's specialty is pain management." The WCJ also issued an Order to the DWC Medical Unit to issue a replacement panel "in the specialty previously issued."

On reconsideration, the WCAB held that under Rule 30, a written objection to an opinion of a treating physician identifying an issue in dispute is not required if the party requesting the QME panel attaches "a request for an examination to determine the compensability under Labor Code section 4060." Applicant's panel request both checked the box indicating that a QME panel was being requested for a "§ 4060 (compensability exam)" and attached a copy of defendant's denial letter dated February 2, 2015. This was sufficient to fulfill Rule 30(b)(1)'s directive and applicant's failure to attach a written objection or a copy of a treating physician's report thus does not invalidate her QME panel request. Next the WCAB addressed defendants objection to applicant's failure to select the specialty for QME panel as that of the primary treating physician. The WCAB held "no requirement that a QME panel issue in the same medical

specialty as that of the primary treating physician. In fact, the Code and Rules explicitly contemplate situations where the specialty of the requested QME panel and the treating physician will differ." The WCAB noted that the "Rule in effect at the time applicant made her request explicitly contemplates situations where the specialty of the QME panel and the treating physician might differ. (Cal. Code Regs., tit. 8, §31.1(b). Clearly, wrote the WCAB "there is no *per se* requirement that a QME panel issue in the same specialty as the treating physician."

Thus the WCAB held that where the applicant properly and timely requested chiropractic panel pursuant to procedure in Labor Code § 4062.2, complied with requirements of 8 Cal. Code Reg. § 30 by indicating that qualified medical evaluator panel was per LC 4600 attaching copy of defendant's denial letter, the specialty was not invalidated simple because specialty selected different from specialty of her treating. Further defendant waived objection to panel by failing to submit written objection to Medical Director asking for review of panel assignment as required under 8 Cal. Code Reg. § 31.5(a)(10); Objection letter by defendant to applicant's counsel was insufficient [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§1.11[3][g], 22.06[1][a], 22. 11[2], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[2], Ch. 19, § 19.37.]; Sullivan on Comp, Section 14.29, Medical-Legal Process – Representing Employee.

§ 31.5. QME Replacement Requests

(a) A replacement QME to a panel, or at the discretion of the Medical Director a replacement of an entire panel of QMEs, shall be selected at random by the Medical Director and provided upon request whenever any of the following occurs:

(1) A QME on the panel issued does not practice in the specialty requested by the party holding the legal right to request the panel.

(2) A QME on the panel issued cannot schedule an examination for the employee within sixty (60) days of the initial request for an appointment, or if the 60 day scheduling limit has been waived pursuant to section 33(e) of Title 8 of the California Code of Regulations, the QME cannot schedule the examination within ninety (90) days of the date of the initial request for an appointment.

(3) The injured worker has changed his or her residence address since the QME panel was issued and prior to date of the initial evaluation of the injured worker.

(4) A physician on the QME panel is a member of the same group practice as defined by Labor Code section 139.3 as another QME on the panel.

(5) The QME is unavailable pursuant to section 33 (Unavailability of the QME).

(6) The evaluator who previously reported in the case is no longer available.

(7) A QME named on the panel is currently, or has been, the employee's primary treating physician or secondary physician as described in section 9785 of Title 8 of the California Code of Regulations for the injury currently in dispute.

(8) The claims administrator, or if none the employer, and the employee agree in writing, for the employee's convenience only, that a new panel may be issued in the geographic area of the employee's work place and a copy of the employee's agreement is submitted with the panel replacement request.

(9) The Medical Director, upon written request, finds good cause that a replacement QME or a replacement panel is appropriate for reasons related to the medical nature of the injury. For purposes of this subsection, "good cause" is defined as a documented medical or psychological impairment.

(10) The Medical Director, upon written request, filed with a copy of the Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021 [see 8 Cal. Code Regs. §§ 14006 and 14007) and the most recent DWC Form PR-2 ("Primary Treating Physician's Progress Report" [See 8 Cal. Code Regs. § 9785.2) or narrative report filed in lieu of the PR-2, determines after a review of all appropriate records that the specialty chosen by the party holding the legal right to designate a specialty is medically or otherwise inappropriate for the disputed medical issue(s). The Medical Director may request either party to provide additional information or records necessary for the determination.

(11) The evaluator has violated section 34 (Appointment Notification and Cancellation) of Title 8 of the California Code of Regulations, except that the evaluator will not be replaced for this reason whenever the request for a replacement by a party is made more than fifteen (15) calendar days from either the date the party became aware of the violation of section 34 of Title 8 of the California Code of Regulations or the date the report was served by the evaluator, whichever is earlier.

(12) The evaluator failed to meet the deadlines specified in Labor Code section 4062.5 and section 38 (Medical Evaluation Time Frames) of Title 8 of the California Code of Regulations and the party requesting the replacement objected to the report on the grounds of lateness prior to the date the evaluator served the report. A party requesting a replacement on this ground shall attach to the request for a replacement a copy of the party's objection to the untimely report.

(13) The QME has a disqualifying conflict of interest as defined in section 41.5 of Title 8 of the California Code of Regulations.

(14) The Administrative Director has issued an order pursuant to section 10164(c) of Title 8 of the California Code of Regulations (order for additional QME evaluation).

(15) The selected medical evaluator, who otherwise appears to be qualified and competent to address all disputed medical issues refuses to provide, when requested by a party or by the Medical Director, either: A) a complete medical evaluation as provided in Labor Code sections 4062.3(i) and 4062.3(k), or B) a written statement that explains why the evaluator believes he or she is not medically qualified or medically competent to address one or more issues in dispute in the case.

(16) The QME panel list was issued more than twenty four (24) months prior to the date the request for a replacement is received by the Medical Unit, and none of the QMEs on the panel list have examined the injured worker.

VII. Medical Treatment: UR/MPN, and MPN

Edilberto Cerna Romero v. Stones and Traditions, State Compensation Insurance Fund, 2016 Cal. Wrk. Comp. P.D. LEXIS 142 (Board Panel Decision)

The applicant's PTP submitted an RFA for four different treatment modalities. The UR physician requested additional information pertaining to two of the treatment modalities and issued a decision within 14 days as required by Labor Code § 4610 as to all four of the treatment modalities. The WCJ reasoned that the UR physician should have issued a decision regarding the two treatment modalities for which no additional information was required within 5 days.

On reconsideration the WCAB disagreed holding that Rule 9792.9.1 provides that an RFA triggers the timelines for completing utilization review and does not contemplate different timelines for different treatment requests within a single RFA. Accordingly, the September 14, 2015 UR decision is timely as to all modalities requested as part of the RFA. See also, Favila v. Arcadia Health Care, Cypress Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 181 (Board Panel Decision) Labor Code § 4610(g)(1), 8 Cal. Code Reg. § 9792.9.1. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10; Sullivan On Comp, 7.35 Utilization Review – Time Limits.]

Bissett-Garcia v. Peace and Joy Center, Virginia Surety Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 174 (Board Panel Decision); Bissett-Garcia v. Peace and Joy Center, Virginia Surety Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 282 (Board Panel Decision);

On September 11, 2015, applicant wrote to defense counsel attaching a PR-2 report from primary treating physician. On the bottom of page 2 of the attached report the PTP wrote, "The patient requires home assistance with [activities of daily living]; 8 hours a day, 7 days a week for cooking, cleaning, self grooming and transportation." On the transmittal letter, applicant's counsel wrote, "Please see the attached PR-2, treating doctor's report from Dr. Vincent J. Valdez 9/08/15. Requesting authorization from home assistance 8 hours a day, 7 days a week. We are asking that this be authorized upon receipt of this letter."

Despite the fact that this "request for authorization" did not comply with Administrative Rule 9792.9.1(a) or Administrative Rule 9792.9.1(c)(2)(B) (Cal. Code Regs., tit. 8, § 9792.9.1, subds. (a) & (c)(2)(B)), defense counsel forwarded the request for treatment to the utilization review process established by defendant pursuant to Labor Code section 4610. On September 17, 2015, defendant's utilization review provider denied the requested treatment. The WCJ held the UR decision untimely and therefore that the WCAB had jurisdiction under Dubon to determine the issue of medical necessity.

On reconsideration the WCAB reversed writing that "according to the utilization review determination, Dr. Valdez's request for treatment was received by the utilization review provider on September 14, 2015. Pursuant to Labor Code section 4610(g)(1) and Administrative Director Rule 9792.9.1(c)(3) (Cal. Code Regs., tit. 8, § 9792.9.1, subd. (c)(3)), defendant had five business days to issue a decision to approve, modify, delay or deny the request. The time runs from the date that a request for authorization "was received by the claims administrator or the claims administrator's utilization review organization." (Administrative Director Rule 9792.9.1(a)(1); Cal. Code Regs., tit. 8, § 9792.9.1, subd. (a)(1).) Thus, defendant's utilization review determination was due September 21, 2015. The September 17, 2015 utilization review denial was well within the time limits. Thus Time limit for UR runs from the date the request for authorization "was received by the claims administrator or the claims administrator's utilization review organization" not from date defense attorney receives request. 8 Cal. Code Reg. § 9792.9.1(a)(1). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10; Sullivan On Comp, 7.36, Independent Medical Review – Procedure; Sullivan On Comp, Section 7.34 Utilization Review – Request for Authorization.] But see conta, Czech v. Bank of America, 2016 Cal.Wrk.Comp.P.D. LEXIS 257 UR found untimely where defense attorney did nothing with request.

Favila v. Arcadia Health Care, Cypress Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 181 (Board Panel Decision)

> *". . . Applicant's contention that the UR and IMR reviewers relied upon outdated medical treatment guidelines and not the most recent studies that applicant claims validate the requested surgery, ignores the mandate that a mistake of fact be of a "matter of ordinary knowledge . . . and not a matter that is subject to expert opinion." The question of whether the proper medical treatment guidelines were used to determine the appropriateness of the disputed surgical treatment is clearly a matter subject to expert opinion and is not a matter of ordinary knowledge. Furthermore, Labor Code section 4610.6(i) expressly precludes the WCJ, the Appeals Board or any higher court from making "a determination of medical necessity contrary to the determination" of the IMR organization. . ."*
>
> *Favila v. Arcadia Health Care, Cypress Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS at pg. 183 (Board Panel Decision)*
>
> *But see, contra, McAtee v. Briggs & Pearson Construction, 2016 Cal.Wrk.Comp. P.D. LEXIS 375(BPD), ordering that new IMR determination pursuant to Labor Code § 4610.6(i) was appropriate where WCAB found that UR determination was result of plainly erroneous express or implied finding of fact as matter of ordinary knowledge based on information submitted for review where IMR reviewer erroneously applied Medical Treatment Utilization Schedule (MTUS) guideline.*
>
> *See also, Gonzalez-Ornelas, v. County of Riverside, 2016 Cal. Wrk. Comp. P.D. LEXIS 151(BPD) where Applicant's IMR appeal pursuant to Labor Code § 4610.6(h)(1) and (5) granted, as IMR determination denying authorization based lack of documentation of diagnosis and failure of conservative treatment, where documentation on both existed and were provided to reviewer -- IMR determination was "plainly and directly contradicted" without need for "expert opinion" within "realm of ordinary knowledge". [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.11; Sullivan On Comp, 7.41, Independent Medical Review – Appeal and Implementation of Determinations]*

Applicant appealed the UR non-certification of the PTP's RFA for artificial disk replacement surgery to IMR. The IMR upheld the UR determination. Applicant than sought review by the Appeals Board arguing should order a second IMR review because the IMR determination was based upon a plainly erroneous expressed or implied finding of fact. Applicant asserted that there is a dispute over the appropriate applicable medical guideline for determining whether the proposed surgery is reasonable, asserting that the UR and IMR physicians relied upon outdated medical information as to the efficacy of the artificial disk replacement surgery.

Labor Code section 4610.6(h) limits the grounds for an appeal from an IMR determination, which determination is "presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:" The ground for appeal cited by applicant is set forth in section 4610.6(h)(5): The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and *not a matter that is subject to expert opinion*.

The WCAB held that a UR denial based on outdated medical treatment guidelines, is not a proper basis for IMR appeal as "plainly erroneous express or implied finding of fact" as described in Labor Code § 4610.6(h)(5) which requires that mistake of fact be matter of ordinary knowledge, not matter subject to expert opinion, and that whether proper medical treatment guidelines were used to determine appropriateness of disputed surgical treatment is clearly matter of expert opinion and not grounds for IMR appeal. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.11; Sullivan On Comp, 7.41, Independent Medical Review – Appeal and Implementation of Determinations]

King v. Comppartners, Inc., (2016 4th Appellate District) 243 Cal. App. 4th 685; 196 Cal. Rptr. 3d 696; 81 Cal. Comp. Cases 10; 2016 Cal. App. Lexis 2.

Applicant sustained injury to back on 2/15/08 and suffered anxiety and depression due to chronic back pain resulting in the psychotropic medication Klonopin being prescribed. In July 2013, a workers' compensation utilization review was conducted to determine if the Klonopin was medically necessary. (Lab. Code, § 4610, subd. (a).) The UR physician determined the drug was unnecessary and decertified it, with applicant required to immediately cease taking the Klonopin. Typically, a person withdraws from Klonopin gradually by slowly reducing the dosage. Due to the sudden cessation of Klonopin, King suffered four seizures, resulting in additional physical injuries. In September 2013 as second authorization request for Klonopin which was submitted to UR and by a second UR physician determined Klonopin was medically unnecessary. Neither UR physician examined applicant in person, nor warned applicant of the dangers of an abrupt withdrawal from Klonopin. Applicant filed a civil complaint seeking damages for negligence arguing that the UR physician owed the applicant a duty of care, which was breached by failure to warn and/or failure to recommend weaning. Defendants demurred to the complaint contending the Labor Code set forth a procedure for objecting to a utilization review decision, and that procedure preempted the Kings' complaint. Alternatively, defendants

asserted that the UR physicians did not owe applicant a duty of care. Defendants argued there was no doctor-patient relationship because they never personally examined Kirk and did not treat him. Defendants reasoned that because there was no relationship, there was no duty of care. The trial judge granted defendant's demur without leave to amend.

The Court of Appeal reversed holding that the UR physician has physician-patient relationship with person whose medical records are being reviewed and, thus, owed applicant a duty of care, that determination of scope of duty owed depends on facts of case, and that, to the extent plaintiffs are faulting utilization review physician for not communicating warning to applicant, their claims are not preempted by exclusivity rule of workers' compensation. Demur sustained with leave to amend. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][c], [d], 22.05[6][b][iii], [iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10[6][b], [7][b].]

Arredondo v. Tri-Modal Distribution Services, 80 Cal. Comp. Cases 1050; 2015 Cal. Wrk. Comp. LEXIS 112 (W/D)

On 10/25/2013, Applicant's primary treating physician, submitted requests for medications, a back brace, and physical therapy. Defendant timely issued a UR determination denying certification. Applicant timely appealed the UR determination through IMR on 12/24/2013 and again on 12/30/2013. On 3/25/2014, before the IMR determination issued but after the timeframe specified in Labor Code § 4610.6(d) for issuance of IMR decisions, Applicant filed a DOR to proceed to expedited hearing regarding his entitlement contending that the IMR determination was invalid because it did not issue within the 30-day time limit described in Labor Code § 4610.6(d) and argued that, because there was no valid IMR, the WCAB had jurisdiction to resolve the parties' dispute over Applicant's entitlement to the requested medications. WCJ concluded that the Administrative Director's failure to issue an IMR determination within the specified time-period did not invalidate the IMR to allow the WCAB to determine medical necessity. Applicant sought reconsideration.

> *See also, accord, SCIF/California Highway Patrol v. WCAB (MARGARIS), 248 Cal. App. 4th 349; 2016 Cal. App. LEXIS 491; Also see, Bolton v. County of San Bernardino, 2016 Cal. Wrk. Comp. P.D. LEXIS 224 (Panel Decision) holding the need for peer review is not exception listed in 8 Cal. Code Reg. § 9792.9.1(f)(1) for extension of 5 day timeframe. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][c], 22.05[6][b][iii]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10[4]. Sullivan On Comp, 7.35, Utilization Review]*

By split panel decision the WCAB upheld the WCJ. The WCAB held that they lacked jurisdiction to review timely utilization review non-certification of requested medical treatment despite the Administrative Director's alleged failure to timely complete independent medical review reasoning that Labor Code § 4610.6(d) timeframes are discretionary, not mandatory, and, therefore, independent medical review determination is valid even if it does not issue within specified timeframes.

Morales v. Pro Armor, 2016 Cal.Wrk.Comp. P.D. LEWIS 378 (BPD)

Applicant after having been released from further care by her MPN PTP, began self -procuring treatment outside of the MPN. At lien trial applicant testified that she was referred for medical treatment by her employer the day after she sustained an injury in a slip and fall accident on September 8, 2011. She testified that she reported injury to her head, shoulders and back for which she was provided treatment in the form of x-rays and medication. After she was released from further treatment by defendant's MPN physician, she obtained legal representation, who referred her to a non-MPN physician who referred her to lien claimant for her psychiatric complaints, which applicant testified first developed after she was told she was being laid off from work. Lien claimants included non-MPN treatment costs and associated translation services. The WCJ denied the lien holding that once applicant was released from care, the applicant could only contest via the MPN procedures pursuant to LC 4616.3 or medical-legal procedures contained in LC 4061 and 4062.

> *. . .If Applicant objected to her treating physician's opinion to release her from care she was required to resolve that dispute by the procedures provided in Labor Code § 4061 and 4062. In this case, Applicant failed to comply with those procedures. Applicant simply elected to treat with a non-MPN doctor, Dr. Rahman. . .*
>
> *Morales v. Pro Armor, 2016 Cal.Wrk.Comp. P.D. LEWIS at pg. 382*

The WCAB held Defendant not liable for lien of non-MPN treatment as no evidence of denial of care, and after release from further medical care with no work restrictions or need for further medical treatment by MPN treater, applicant may only contest the MPN treater's opinion via MPN procedures pursuant to Labor Code § 4616.3, or med-legal procedures pursuant to Labor Code §§ 4061 and 4062. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[8][b].]

Luna v. The Home Depot, 2016 Cal. Wrk. Comp. P.D. LEXIS 405 (Split BPD)

> *§ 9767.5. Access Standards*
>
> *(a) A MPN must have at least three available physicians of each specialty to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged and within the access standards set forth in (1) and (2).*
>
> *(1) An MPN must have at least three available primary treating physicians and a hospital for emergency health care services, or if separate from such hospital, a provider of all emergency health care services, within 30 minutes or 15 miles of each covered employee's residence or workplace.*
>
> *(2) An MPN must have providers of occupational health services and specialists who can treat common injuries experienced by the covered injured employees within 60 minutes or 30 miles of a covered employee's residence or workplace. . .*

Applicant filed a Petition to Reopen for New and Further Disability on September 10, 2015. He subsequently filed a Declaration of Readiness to Proceed to Expedited Hearing on the issue of his entitlement to obtain medical treatment outside defendant's MPN, due to the absence of orthopedists to act as his primary treating physician within 15 miles of his home or his employer's zip code.

The matter was tried on June 16, 2016, on the issue: "Whether Applicant is entitled to treat outside of the MPN with a physician of his own choice due to Defendant's failure to comply with MPN access standards set forth in Title 8, CCR 9767.5(a) and 9767.5(a)(1)." The parties stipulated that "there is one orthopedic surgeon within 15 miles and seventeen orthopedic surgeons within 30 miles from the injured worker's residence and the employer's zip code."

The WCJ concluded that because applicant sought an orthopedic surgeon, a specialist, to be his primary treating physician, the MPN need only meet the 30 mile/60 minutes access standard for selection of a specialist and not the 15 mile/30 minute access standard applicable to the selection of a primary treating physician.

WCAB panel majority found that because applicant sought specialist in orthopedic surgery to be his primary treating physician, defendant's MPN need only meet 30 mile/60 minute access standard for selection of specialist under 8 Cal. Code Reg. § 9767.5(a)(2) and not 15 mile/30 minute access standard applicable to selection of primary treating physician under 8 Cal. Code Reg. § 9767.5(a)(1).; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[4].]; Sullivan on Comp, Section 7.53, Medical Provider Network – Establishment and Maintenance.

Farias v. Able Building Maintenance, Zurich North America, 2016 Cal. Wrk. Comp. P.D. LEXIS 440 (Board Panel Decision).

> *ZZZEditor's Comments: First be advised this is a split panel decision and therefore is of limited value. Second, note that Commissioner Sweeney in here dissenting opinion I believe raised the real issue: if the transfer of care requirements are absent from the CBA, either Labor Code Section 4603.2 should be applied or the CBA provisions concerning applicant's entitlement to medical treatment should be deemed "void" as a diminishment of applicant's California Workers' Compensation Benefits. Though. Collective bargaining the employer should not be allowed to reduce Worker's Compensation benefits but merely to create an alternative delivery system.*
>
> *In conclusion, the majority's decision in Farias is best summarized as holding that where the medical treatment is "negotiated" pursuant to a CBA, it does not really matter what the specific provisions of the medical treatment benefit are or whether those provisions serve to diminish the employee's rights to medical treatment under the Workers ' Compensation System. According to the State of California's statistics, there are at least 34 ADR programs operating in California. As more ADR's are established, how Labor Code Section 3201.5(b)(1) and Labor Code Section 3201.7(b)(1) are interpreted will become increasingly important.*

By split panel opinion, applicant who suffered CT ending 1/22/14 and was treating outside of alternative dispute resolution (ADR) agreement based on denial of her claim by defendant, was required to transfer treatment to ADR agreement's exclusive provider network after defendant accepted her claim, pursuant to provisions in Labor Code § 3201.5 and terms of ADR agreement reasoning that (1)that agreed list of medical providers in ADR agreement differs from medical provider networks (MPN) established pursuant to Labor Code § 4616, (2) that MPNs are regulated by Administrative Director and subject to statutory constraints such as those in Labor Code § 4603.2(a)(2) addressing transfer of treatment into MPN, (3) that Labor Code § 3201.5 allows use of agreed list of treaters and allows parties to agreement to negotiate any aspect of medical treatment delivery, (4) and that MPN statutes,

including Labor Code § 4603.2, do not apply to medical treatment negotiated pursuant to collective bargaining agreement.

Noteworthy was Commissioner Sweeney dissenting opinion. Commissioner Sweeney noted that since ADR agreement was silent on transfer of care after employee has self-procured treatment from provider who is not on agreed provider list, and there was no dispute resolution mechanism for this dispute, MPN provisions in Labor Code, which allow employee to continue treatment with doctor outside employer's MPN when there has been final determination that employee was entitled to treat outside MPN. Requiring applicant to transfer care is a diminishment of applicant's entitlement to medical benefits and that portion of bargaining agreement that diminishes applicant's entitlement to benefits should be held null and void as a matter of public policy. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 1.04A; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, § 3.04[3]; Sullivan on Comp, Section 3.5, Carve-Outs]

VIII. Permanent Disability

Constantino v. Queenscare, Alea North America, 2016 Cal. Wrk. Comp. P.D. LEXIS 35 (BPD)

Applicant sustained industrial injury to her back, right shoulder, and psyche while employed as a department secretary. Relying on the opinion of the AME the WCJ awarded applicant permanent disability of 70% and the need for further medical treatment finding that the applicant had successfully rebutted the scheduled American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides) component of the permanent disability rating pursuant to *Milpitas Unified School District v. Workers' Comp, Appeals Bd*. (*Guzman*) (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837], and utilized an alternate method purportedly within the four comers of the AMA Guides to determine the applicant's low back whole person impairment. In determining that that standard rating was not accurate the AME wrote, "I do not feel that the impairment using the standard AMA Guides rating system is accurate. The Guides do not take into consideration pain or subjective factors, and does not take into consideration work restrictions or inability to resume the pre-injury occupation" without further explaining or analysis.

In reversing the WCJ, the WCAB wrote, "Dr. Fedder does not sufficiently explain why applicant's impairment is not adequately reflected by the AMA Guides. Dr. Fedder's criticism that . . . "The Guides do not take into consideration pain or subjective factors, and does not take into consideration work restrictions or inability to resume the pre-injury occupation," is directed at the AMA Guides as a whole, not the specific impairment applicable to this case."

Therefore, the opinion of AME did not constitute substantial evidence where AME failed to explain why standard rating was not accurate, but merely criticized the AMA guides for failing to accurately reflect pain or subjective factors. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4][a], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation, Ch. 8; Sullivan on Comp, 10.18 Permanent Disability – Rebutting Schedule Under Guzman.]

Wright v. Michael's, 2015 Cal. Wrk. Comp. P.D. LEXIS 455 (Panel Decision)

Editor's Comments: The Wright decision contains an excellent application of the doctrine of "direct causation" and the principle "synergy". In the Wright decision the VR expert, and evaluating QME's all properly focused on the "causation of disability" and that the "disability" be directly caused exclusively by the subject industrial injury. The industrial disability included the limitation caused by effects of the (1) physical industrial injury, (2) industrial component of the psychiatric injury, (3) effect from prescribed medication, and the (4) synergic effect of the three which rendered the applicant totally disabled.

But see, Johnson v. Wayman Ranches, 2016 Cal. Wrk. Comp. P.D. LEXIS 235 (Panel Decision) holding that simply using the word "synergistic" does not suffice to constitute substantial evidence, rather the physicians must explain how separate disabilities are acting in synergistic fashion and why adding disabilities rather than using CVE is a more accurate reflection of applicant's disability.

The injured worker injured her back on 1/28/2008 when she was moving outside bins immediately developing excruciating pain in her low back, which went down her right buttocks and leg. Applicant underwent two surgeries on her low back. She did not have much improvement with the first surgery, which resulted in her back feeling unstable. The second surgery stabilized her back but the pain did not go away. Her incontinence problems have not changed since about the date of injury. Applicant was prescribed a myriad of medications including OxyContin, Oxycodone, Norco, Miralax, Milk of Magnesia, Lyrica, Ibuprofen, Nexium and Medical Marijuana to control her pain and counteract the side effects of the pain medications.

She tries to control her incontinence by visiting a restroom every 2 hours. Because of the injury, she is unable to determine if her bladder is full. She has been told there is nothing that can be done to fix the incontinence.

Applicant VR expert found that applicant had lost 100% of her future earning capacity due to the industrial injury based upon the work restrictions put into place by the ortho QME and psychiatric and that applicant had a total loss of earning capacity based on the synergistic effect of the functional limitations as set for by the medical evaluators and the prescribed medication. He further opined that this loss was solely due to her industrial injury. This opinion was support by the ortho QME who found the applicant incapable of working due to a combination of all factors including prescription medications. The psych QME apportioned 30% of applicant's psychiatric disability to non-industrial causation. However, when considering all factors even the psych QME found the applicant to be totally disabled. The WCJ found for the applicant awarding 100%.

On reconsideration, the WCAB upheld the WCJ. The WCAB wrote that the Applicant was 100% disabled based on the opinions of VR expert, Ortho AME, despite the fact that psych AME would apportion 30% to nonindustrial factors where psych AME also clearly concluded that applicant was currently unemployable due to effects of numerous industrial prescribed medications in conjunction with her psychiatric injury. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4][a], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation, Chs. 3, 4, 5, 10.]

Ortega v. Building Technologies, Inc., Granite State Insurance Company, administered by AIG Claims, Inc., 2015 Cal. Wrk. Comp. P.D. LEXIS 395 (Panel Decision)

Applicant suffered injury on October 21, 2004 when a metal strap with an attached screw snapped free and punctured applicant's right eye. Applicant underwent multiple surgeries to the eye. Applicant has significant impairment to his vision in the right eye, approaching blindness. On the date of injury, applicant's vision in his left eye was measured as 20/20. (Exhibit 14, Record Excerpts from Kaiser Permanente at pp. 62–63.) However, applicant subsequently sustained non-industrial injury to the left eye due to both glaucoma and a cataract. This non-industrial injury occurred prior to applicant becoming permanent and stationary in the right eye. When applicant was rated for permanent disability, applicant's left eye vision was correctable to 20/50 reflecting significant impairment which was determined to impact on the vision in the industrially injured right eye. The WCJ awarded applicant 40 WPI based on the opinion of the AME who focused only on the

> "…*Unlike an arm or a leg, eyesight is unique because the eyes are inherently intertwined and work together as one system. (AMA Guides at p. 277.) The AMA Guides heavily skews impairment of the visual system to the measurement of binocular vision. (See supra.) Due to this unique characteristic, the logic of Wilkinson should apply when determining causation of permanent disability due to successive injury to the eyes. Thus, to apportion disability where successive industrial and non-industrial injuries combine to cause impairment to binocular vision, the evaluator must 1) determine the disability of the vision system as a whole, 2) determine what, if any, disability resulted from the non-industrial injury alone, and then 3) subtract the non-industrial disability from the disability of the whole vision system. (AMA Guides at p. 12.) In determining apportionment to binocular vision, the evaluator must specifically determine whether applicant would have binocular vision impairment but for the industrial injury. In this case, that answer is "no".*
>
> *Applicant's right eye could have compensated for the non-industrial injury to the left eye, but for applicant's industrial injury. The binocular measurements, with some exceptions, are generally reflective of the score in the better eye. (Id. at Chapters 12.2b.4, p. 282, 12.3a.5, p. 287.) After applicant's industrial injury, applicant's left eye was the better eye. The left eye worsened over time due to non-industrial conditions. The worsening of applicant's left eye decreased applicant's total binocular vision scores, which, in turn, increased applicant's disability. Although applicant's vision in the non-industrial left eye worsened over time, applicant's left eye condition would not have resulted in permanent impairment of applicant's binocular vision without the near total loss of vision to the right. The two eyes are intertwined and work together. The binocular scores are based on the left eye solely because the right eye is severely injured. Thus, the binocular impairment from both eyes is industrial.*
>
> *The QME's apportionment analysis did not constitute substantial medical evidence. The QME adjusted both the left eye monocular measurement and the binocular measurements, under the belief that doing so would ameliorate any increase in applicant's disability caused by the left eye. (Exhibit 1, Report of Armin Vishteh, M.D., dated July 11, 2012 at pp. 6–7.) The QME created fictional measurements as if the left eye still had 20/20 vision, as measured on the date of injury. (Id.) The QME artificially inflated the acuity and field scores to 100 and 80 respectively, which would reflect the proper scores if applicant's left eye had never worsened. (Id.; AMA Guides, Tables 12–2 and 12–5, pp. 284 and 289.) The QME then opined that apportionment of the final vision rating was not necessary, because the QME removed any impact that the left eye had on the rating. (Exhibit 1 at pp. 6–7.) On the surface, it would appear as if this method properly deducted any non-industrial disability from applicant's rating. However, because applicant is near blind in his industrial eye and because the eyes are intertwined and work together as a group, the cause of applicant's binocular vision loss is industrial. It was error for the QME to adjust applicant's binocular measurements with fictitious values in rating his disability."*
>
> *Ortega v. Building Technologies, Inc., Granite State Insurance Company, 2015 Cal. Wrk. Comp. P.D. LEXIS at pg.399.*

impairment rating in the industrial injured right eye without regards to the "uniqueness" of eyesight and that the eyes are " inherently intertwined",

In reversing, the WCAB found that combined awards of permanent disability for successive injuries pursuant to *Wilkinson v. W.C.A.B*. (1977) 19 Cal. 3d 491, 138 Cal. Rptr. 696, 564 P.2d 848, 42 Cal. Comp. Cases 406, although generally not permitted, are allowed to determine disability due to successive industrial and nonindustrial eye injury because left and right eyes are inherently intertwined and work together as one system due to unique nature of eye impairment. Further, where successive industrial and nonindustrial injuries combine to cause impairment, the evaluator to apportion disability pursuant to Labor Code § 4663, must determine disability as a whole, then determine what, if any, disability resulted from nonindustrial injury alone, and then subtract nonindustrial disability from disability of whole vision system. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4][a], 8.05[1]-[3], 8.07, 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.12, 7.40[1], 7.42[1], [2], [4]; The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation, Chs. 3, 4, 9.]

Montenegro v. City of Los Angeles, PSI, 2016 Cal. Wrk. Comp. P.D. LEXIS 129 (Panel Decision)

Applicant was a firefighter who sustained industrial prostrate cancer which resulting in removal of his prostrate resulting in sexual dysfunction. The parties stipulated that the rating with sexual dysfunction would rate 78% and 74% without. Defendant argued that applicant was precluded from an impairment rating for sexual dysfunction pursuant to Labor Code § 4660.1(c)(1). The matter proceeded to MSC with the parties stipulating that the rating with sexual dysfunction would rate 78% and 74% without. The WCJ found for the applicant awarding 78% PD reflecting erectile dysfunction.

In upholding the WCJ, the WCAB relied in part of *Guzman* and LC 4660.1(h). Next the WCAB analyzed "compensable consequence" finding that this case involved a direct injury to the prostate that resulted in a prostatectomy. It was the removal of the prostate gland which made ejaculation more difficult noting the urethra runs though the center of the prostate gland. This matter the WCAB held involved a direct not a compensable consequence injury.

> *"It is well settled law that an evaluating or treating physician must find the most accurate rating in a given case. In fact, under Labor Code § 4660.1(h), the legislature specifically addressed the limitations of other sub-sections in § 4660.1 by stating: "In enacting the act adding this section [4660.1], it is not the intent of the legislature to overrule the holding in Milpitas Unified School District v. WCAB (Guzman) (2010) 187 Cal.App. 4th 808." The facts of the instant case reflect that legislative mandate. Dr. Agatstein utilized the four corners of the AMA Guides to assign the most accurate ratings for the Applicant's prostate cancer and the devastating effects the surgery for that cancer caused in terms of surgical physical damage to the reproductive system and the direct consequences of that damage—the resulting sexual dysfunction. This case falls under the legislative exception to § 4660.1(c)(1) which is enunciated under § 4660.1(h).*
>
> *The Defendant contends that Applicant's sexual dysfunction resulted from medical treatment for the underlying industrial injury to the prostate; thus the outcome, the lack of a prostate, is nothing more than a "compensable consequence." However, an injury to the prostate, in terms of sexual dysfunction, cannot be considered compensatory by the very definition of the word. The prostate is described as part of the internal organs of the male reproductive system, also called accessory organs. The prostate gland is a walnut-sized structure that is located below the urinary bladder in front of the rectum. The prostate gland contributes additional fluid to the ejaculate. Prostate fluids also help to nourish the sperm. The urethra, which carries the ejaculate to be expelled during orgasm, runs through the center of the prostate gland. (Emphasis added) It is for those reasons that the Defendant's contention must fail."*
>
> *Montenegro v. City of Los Angeles, PSI, 2016 Cal. Wrk. Comp. P.D. LEXIS at p. 130.*

Thus, Labor Code § 4660.1(c)(1) does not preclude increased impairment rating for sexual dysfunction caused by removal of his prostate to treat his industrial prostate cancer, where sexual dysfunction was direct result from physical injury and not simply a derivative/consequential effect of physical injury noting that impairment should be assessed within four corners of AMA *Guides* to achieve most accurate rating of injured employee's permanent disability.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4][a], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation, Chs. 3, 8; Sullivan On Comp, 10.16, Use of 2013 Permanent Disability Schedule.]

IX. Procedure -- WCAB

Rosenberg v. State of California, California Highway Patrol Disability and Retirement, 2016 Cal. Wrk. Comp. P.D. LEXIS 57 (Panel Decision)

Although applicant failed to raise the issue of TD at MSC on the Conference Statement, TD was raised as an issue at Trial. Defendant failed to object at trial, objecting for the first time on reconsideration before the WCAB. The WCAB in upholding the WCJ's award of TD held that issues set forth at trial supersede list of issues at mandatory settlement conference, and, defendant waived right to object to issue of temporary disability by failing to object at trial. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 26.04[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.35; Sullivan On Comp, 15.32, Litigation – Mandatory Settlement Conference.]

Dunn v. Bright Pool Services, 2016 Cal.Wrk.Comp. P.D. LEXIS 200 (BPD)

"Benefits notice" held insufficient to trigger statute of limitations where it failed to inform applicant of her workers' compensation rights and remedies or ability to disagree or challenge carrier's findings absent showing of applicant's actual knowledge of entitlement to workers' compensation *citing Reynolds v. WCAB (1974) 12 Cal. 3d 726, 117 Cal. Rptr. 79, 527 P.2d 631, 39 Cal. Comp. Cases 768, and Kaiser Found. Hosps. Permanente Medical Group v. W.C.A.B. (MARTIN) (1985) 39 Cal. 3d 57, 216 Cal. Rptr. 115, 702 P.2d 197, 50 Cal. Comp. Cases 411. DUNN v. Bright Pool Services, 2016 Cal. Wrk. Comp. P.D. LEXIS 200 (BPD)*; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 24.03[1], 24.04[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 14, §§ 14.01[4], 14.02[1]; Sullivan On Comp. 6.17, Estoppel Based on Failure to Provide Notice.]

Rivas v. Oltman's Construction Co., Travelers Property Casualty Co. Of America, 2016 Cal. Wrk. Comp. P.D. LEXIS 53 (Panel Decision).

Applicant filed an application for adjudication of claim on February 17, 2015. On 3/3/15 and 8/10/15, defendant filed successive petitions to dismiss this claim alleging that an ADR agreement existed and that applicant was bound to pursue his claim through the ADR process. Both petitions were denied for various reason including insufficient information to determine whether the ADR agreement applied to applicant. On October 15, 2015, applicant filed a declaration of readiness to proceed (DOR) to an expedited hearing on the issues of medical treatment and temporary disability. Defendant did not object to the DOR.

On applicant's DOR, this matter proceeded to an expedited hearing on November 10, 2015. At the hearing the parties entered into stipulations providing for medical treatment, temporary disability, and to resolve the lien of EDD. The parties reserved jurisdiction on the issue of penalties. Defendant signed the stipulations and submitted them for approval along with a joint request that this matter be taken off calendar.

On November 20, 2015, defendant filed a third petition to dismiss, alleging the same facts as before. Than on 11/30/15 defendant sought to set aside through petition for reconsideration the prior stipulation asserting the WCJ was without jurisdiction given the ADR agreement. Defendant attached two exhibits in support of the petition: "Workers' Compensation Addendum to The Current Collective Bargaining Agreement between The Southwest Regional Council of Carpenters Affiliated with the United Brotherhood of Carpenters and Joiners of America and The Signatory Employer;" And a letter from the Acting Administrative Director to the Carpenters-Contractors Workers' Compensation Trust for Southern California titled "Renewal of Section 3201.5 Letter of Eligibility". The union's eligibility is renewed effective August 15, 2013 and continuing through August 14, 2016.

The WCAB first noted Stipulations are binding on the parties unless, on a showing of good cause, the parties are given permission to withdraw from their agreements citing *County of Sacramento v. Workers' Comp. Appeals Bd. (Weatherall) (2000) 77 Cal.App.4th 1114, 1121; 65 Cal.Comp.Cases 1.* Second, the WCAB held that the burden of proof is on defendant to provided sufficient evidence establishing binding alternative dispute resolution(ADR) system pursuant to Labor Code § 3201.5, in the absence to such evidence WCJ has subject matter jurisdiction and defendant is bound by previously approved stipulation. Defendant did not satisfy their burden of proof. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.04A, 26.06[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 3.04[3], Ch. 16, § 16.23; Sullivan On Comp, 15.111, Alternative Dispute Resolution/Carve-Outs]

Orellana v. Pro Wash, Inc., State Compensation Insurance Fund, 2016 Cal. Wrk. Comp. P.D. LEXIS 401 (BPD).

Applicant filed DOR relying solely on the opinion on the PTP without objection by Defendant. The matter was set for MSC at which time defendant objected to the matter being set for trial. Defendant asserted that LC 4061(i)

provides that a matter should not be the subject of a DOR until there is both a PTP report and either an AME or PQME report. The WCJ held for the applicant and set the matter for hearing with defendant seeking review by removal.

In upholding the WCJ, the WCAB acknowledged that *Labor Code* § 4061(i) does indeed provide that a matter should not be the subject of a DOR until there is both a PTP report and either an AME or PQME report. However, Rule 10416 provides that if a party fails to object to a DOR, that any objection they may have had to it will be deemed waived. Reading the two together, by failing to object to the DOR, defendant has waived the requirements of *Labor Code* § 4061(i.) The WCAB further believed that *Labor Code* § 4061(i) is not specific enough to a repeal Rule 10416. *Labor Code* § 4061(i) although if there were a contradiction, clearly the *Labor Code* section would control over the regulation. Since there is no reason to believe that the rights contained in § 4061 may not be waived, Defendant is still required to object to the DOR to assert these rights. Removal denied.

X. Psychiatric Injury

Travelers Casualty & Surety Company v. Workers' Compensation Appeals Board (Dreher) 2016 Cal. App. Lexis 321

Applicant was employed as a live-in maintenance supervisor for an apartment complex. As he was walking in the rain to another building in the complex, Applicant slipped and fell on a slippery concrete walkway. He had worked for the apartment complex less than 6 months at the time of injury. Applicant fractured his pelvis and claimed injuries to his neck, right shoulder, right leg, and knee; He also suffered gait derangement, a sleep disorder, headaches and ultimately psychiatric injury arising from the accident. Applicant was evaluated in June 2011. The evaluator concluded that applicant suffered a psychiatric disability as a result of the accident, including depression, difficulty sleeping, and panic attacks. After hearing, the WCJ found the claim barred by LC 3208.3 as applicant did not have an aggregate of 6 months of employment at time of injury. On reconsideration the WCJ was reversed, with the WCAB finding that the injury was caused by an extraordinary employment condition and thus was not barred by section 3208.3(d). Defendant sought writ of review.

". . . the claimant's accident was not extraordinary within the meaning of Lab. Code, § 3208.3. The evidence showed that the claimant routinely walked between buildings on concrete walkways at the work site and that he slipped and fell while walking on rain-slicked pavement. The claimant's testimony that he was surprised by the slick surface of the walkway because the other walkways had a rough surface, and his further testimony that the walkway was later resurfaced, did not demonstrate that his injury was caused by an uncommon, unusual, or totally unexpected event. The claimant's slip and fall was the kind of incident that could reasonably be expected to occur. Because the injury was not the result of a sudden and extraordinary event, the claimant's psychiatric injury claim was barred under § 3208.3, subd. (d). . ."

Travelers Casualty & Surety Company v. Workers' Compensation Appeals Board (Dreher) 2016 Cal. App. Lexis at pg. 324

Editor's Comments: The Dreher decision is simply application of the requirement the injurious activity or event causing injury must not be "a risk inherent in the employment activity", "routine or a common" or an "expected event" for it to be "extraordinary" under LC 3208.3. Further, of course it is the applicant who has the burden of proof on the issue of establishing "sudden and extraordinary" as it is the applicant "who benefits from the affirmative of the issue."

See also, accord, Travelers Casualty & Surety Company v. Workers' Compensation Appeals Board (DREHER) 2016 Cal. App. Lexis 321, holding that applicant has burden of proof to establish accident was "sudden and extraordinary" as an exception to six month employment requirement Lab. Code, § 3208.3, and where activity was "routine, and not uncommon, unusual, or a totally unexpected event" and thus one which could "reasonably be expected to occur" it will not be "extraordinary. See also, SIMARD v. Lowe's Home Center, 2016 Cal.Wrk.Comp. P.D. LEXIS 214 (BPD), in which applicant was moving refrigerator down stairs and fell, with refrigerator landing on top of him, psych injury was not barred by six month employment requirement where refrigerator falling down stair was determined to be "sudden and extraordinary". [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.02[3][d]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[3][c].], 2016, Sullivan On Comp, Chpter 5, Section 5.31.

See also, accord, Doerna v. Layner Christensen Co., 2016 Cal.Wrk. Comp. P.D. LEXIS 393, that jumping to avoid a large wrecking ball when cable holding snapped held "sudden and extraordinary under LC 3208.3 as exception to six month rule.[See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.02[3][d]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[3][c].]; Sullivan on Comp, Section 5.31, Psychiatric Injury – Six Month Rule.

See also, State of California, Department of Corrections and Rehabilitation (California Men's Colony), v. Workers' Compensation Appeals Board, (Van Dyk) (Court of Appeal, 2nd Appellate District) 81 Cal. Comp. Cases 458; 2016 Cal. Wrk. Comp. LEXIS 51 (Writ of Review Denied), which held that successive injuries may be combined to meet burden predominant cause of psychiatric injury despite the fact that the second injury alone did not meet 51 percent predominant causation standard, where two injuries combined amounted to the requisite greater than 50% industrial cause.

The Court of Appeal annulled the WCAB's decision and remanded the matter. The court concluded that (1) it is the applicant who has burden of proof to establish accident was "sudden and extraordinary" as an exception to six month employment requirement Lab. Code, § 3208.3, and (2) where activity was "routine, and not uncommon, unusual, or a totally unexpected event" and thus one which could "reasonably be expected to occur".. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.02[3]d]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[3][c].], 2016, Sullivan On Comp, Chpter 5, Section 5.31.

Larsen v. Securitas Security Services, 2016 Cal. Wrk. Comp. P.D. LEXIS 237 (Board Panel Decision)

Applicant, a security guard sustained an accepted industrial injury to her neck, back, and bilateral shoulders as a result of being hit by a car while walking through a parking lot on February 21, 2013. Applicant also alleged injury to her psyche as a result of the accident. Applicant sought PD for physical and psychiatric injury as a compensable consequence arguing that the accident constituted a "violent act", an exception to the LC 4660.1 prohibition to PD resulting from psychiatric injury as a compensable consequence of the physical industrial injury. The WCJ found that applicant's psychological permanent disability resulted from a "violent act" in accordance with Labor Code section 4660.1(c) and thus was compensable. Defendant sought reconsideration.

> *". . . Black's Law Dictionary defines 'violent' as follows:*
> *1. Of, relating to, or characterized by strong physical force <violent blows to the legs>.*
> *2. Resulting from extreme or intense force <violent death>. 3. Vehemently or passionately threatening <violent words>. (Black's Law Dictionary (7th ed. 1999).)*
>
> *. . . Here, applicant was struck by a car in a parking lot where she was conducting a walking patrol as a security guard. Furthermore, the evidence establishes that applicant was hit from behind with enough force to cause her to fall, hit her head, and lose consciousness. Being hit by a car under these circumstances constitutes a violent act. Applicant was therefore a victim of a 'violent act' within the definition of section 3208.3(b). Thus, applicant is entitled to additional permanent disability for her psychological injury as an exception to section 4660.1(c). . .*
> *"To perpetrate" is defined as: "To commit or carry out (an act, especially a crime)[.]" (Black's Law Dictionary (7th ed. 1999).) The Legislature has indicated a requirement that a violent act be 'perpetrated' upon the victim within numerous other statutes, but has omitted such language from section 3208.3. Thus, we conclude that for purposes of section 3208.3, a "violent act" is not limited solely to criminal or quasi-criminal activity, and may include other acts that are characterized by either strong physical force, extreme or intense force, or are vehemently or passionately threatening.*
>
> *Larsen v. Securitas Security Services, 2016 Cal. Wrk. Comp. P.D. LEXIS at pg. 241*

The WCAB upheld the WCJ finding that Labor Code § 3208.3(b), "violent act" is not limited solely to criminal or quasi-criminal activity, and may include other acts that are characterized by either strong physical force, extreme or intense force, or are vehemently or passionately threatening, including being hit by car from behind with enough force to cause lose consciousness. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 4.02[3][a], [b], [f], 4.69[1], [3][a], 8.02[4][c][ii], [5], 32.02[2][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.05[3][b][i][ii], 7.06[6], Ch. 10, § 10.06[3][a], [b][i]. 10.16; Sullivan On Comp, 10.16, Use of 2013 Permanent Disability Schedule.]

XI. Statute of Limitations

Galland v. Los Angeles Unified School District, 2016 Cal.Wrk. Comp. P.D. LEXIS 69 (BPD)

> *"Report of occupational injury confirming that Defendant provided claim form was sufficient to shift burden onto applicant to establish employer failed to provide claim form or applicant's lack of actual knowledge of worker's compensation rights where applicant asserts tolling of LC 5405 statute of limitation. See also, Ostini v. Alma Rosa Winery & Vineyard, Inc. 2016 Cal.Wrk.Comp. LEXIS 76. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 24.03[1], 24.04[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 14, § 14.15; Sullivan On Comp, 6.17 Statute of Limitations – Estoppel Based on Failure to Provide Notice.] The running of the statute of limitations is an affirmative defense, and the burden of proving it is on the party opposing the claim. (Lab. Code, § 5409; Kaiser Foundation Hospitals v. Workers' Comp. Appeals Bd. (Martin) (1985) 39 Cal.3d 57, 67, fn. 8 [50 Cal.Comp.Cases 411].) The burden is on defendant to show when the statute of limitations began to run, "starting from any and all three points designated [in Labor Code section 5405]." (Colonial Ins. Co. v. Industrial Acc. Com. (Nickles) (1945) 27 Cal.2d 437, 441 [10 Cal.Comp.Cases 321].) The three points designated in section 5405 are date of injury (Lab. Code, § 5405, subd. (a)); the last payment of disability indemnity (Lab. Code, § 5405, subd. (b)); and the last date on which medical treatment benefits were furnished (Lab. Code, § 5405, subd. (c)). . . "*
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> *"[A]s a general rule, where a claimant asserts exemptions, exceptions, or other matters which will avoid the statute of limitations, the burden is on the claimant to produce evidence sufficient to prove such avoidance. (Permanente Medical Group v. Workers' Comp. Appeals Bd. (Williams) (1985) 171 Cal.App.3d 1171, 1184 [50 Cal.Comp.Cases 491].) One such exemption or exception is that the statute is tolled by an employer's failure to notify an injured employee of a potential right to benefits, as required by Labor Code section 5401(a). (Martin, supra, 39 Cal.3d at p. 60.)*
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> *Thus, when applicant asserts that the statute is tolled based on the breach of the duty to provide the employee with notice of potential right to benefits, applicant has the duty of showing that defendant had sufficient notice of injury to provide applicant with a claim form. The duty then shifts to defendant to show that the claim form was sent to the applicant or that applicant had actual knowledge of his workers' compensation rights. (Martin, supra, 39 Cal.3d at pp. 60, 65; Sidders v. Workers' Comp. Appeals Bd. (1988) 205 Cal.App.3d 613, 622 [53 Cal.Comp.Cases 445].) However, once the employer has provided the applicant with written notice of his workers' compensation rights, or applicant gains the requisite actual knowledge of his rights, the tolling period ends. (Martin, supra, 39 Cal.3d at p. 65.)"*
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> *Galland v. Los Angeles Unified School District, 2016 Cal.Wrk. Comp. P.D. LEXIS at pg. 71-72*

The applicant while employed as a teacher on July 20, 2009, sustained industrial injury to his back. The evidentiary record includes an Employer's Report of Occupational Injury or Illness dated August 14, 2009, which stated a claim form was provided to the applicant on August 13, 2009. There is no contradictory documentary evidence or testimony, including the fact that applicant never testified that he did not receive a DWC-1. Defendant's human resource manager testified that she was not "a hundred percent sure if [applicant] reported a work-related injury," but "[i]f he came in and said he was injured, she would have provided a claim form to him" consistent with the Employer's Report of Occupational Injury. Despite this un-contradicted evidence, the WCJ found that the defendant did not carry its burden of proving that applicant was provided a claim form because "none of the defendant's witnesses testified that a claim form was given to the applicant."

In reversing the WCJ, the WCAB on reconsideration wrote "it is also not surprising that defendant's human resource manager was not "a hundred percent sure" of the facts of the case over six years after the occurrence of the facts that she was expected to testify to. The purpose of statutes of limitation is to "ensure that plaintiffs proceed diligently with their claims and mitigate the difficulties faced by defendants in defending stale claims, where factual obscurity through the loss of time, memory or supporting documentation may present unfair handicaps." (*Bernson v. Browning-Ferris Industries* (1994) 7 Cal.4th 926, 935.) Additionally, the testimony of defendant's human resource manager that she would have ordinarily provided a claim form to whomever claimed injury to him constitutes evidence that she did so on that specified occasion. (Evid. Code, § 1105.) , Therefore, the WCAB found that (1) applicant was provided with a claim form on August 13, 2009, and thus any tolling of the statute expired on that day; (2) No evidence was presented regarding whether applicant filed the claim form with the employer, and assuming the claim form was filed with the employer on the date the applicant received it, defendant denied the applicant's claim on October 16, 2009, within 90 days of the filing of the claim form (Lab. Code, § 5402, subd. (b).); and (3) Pursuant to Labor Code section 5401(d), "Filing of the claim form with the employer shall toll, for injuries occurring on or after January 1, 1994, the time limitations set forth in Sections 5405 and 5406 until the claim is denied by the employer or the injury becomes presumptively compensable pursuant to Section 5402." Thus, assuming a claim form was filed, the statute of limitations was tolled until the October 16, 2009 denial. Applicant had one year from the denial to file an application for adjudication of claim. However, applicant did not file until November 6, 2013, more than three years after the latest possible date the statute of limitations had expired. Recon granted for defendant, reversed with order that applicant take nothing.

XII. Subrogation – Third-Party Recovery

Collazo v. Global Manufacturing, AIG Claims, 2016 Cal. Wrk. Comp. P.D. LEXIS 86 (BPD)

In order to receive credit, the defendant has the burden of proof to establish what portion of applicant's civil settlement is subject to credit. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 11.02[1], [2], 11.42[5]; Rassp & Herlick, California Workers' Compensation Law, Ch. 12, § 12.09[6].]

Hartzheim Dodge, Inc., et al. v. Workers' Compensation Appeals Board, Juan Navarro, (Court of Appeal, 1st Appellate District) 81 Cal. Comp. Cases 362; 2016 Cal. Wrk. Comp. LEXIS 43 (Writ Denied)

On 7/14/2005, several employees physically attacked Applicant. The men strapped Applicant to a chair, and, when Applicant fell over onto his back, one employee lay on top of him, while another pulled off Applicant's pants and underwear, lifted up his legs, and used a marker to draw a heart on Applicant's buttock. Applicant was injured in the struggle. Applicant reported the incident to his manager who did nothing. This was one of a number of assaults over a five-month period.

Applicant filed a civil suit against Defendant on 2/16/2007, alleging causes of action for physical injuries and emotional distress from the sexual harassment and abuse specifically alleging: (1) sexual harassment, (2) failure to take reasonable steps necessary to prevent sexual harassment from occurring, (3) negligence in hiring, supervision, and retention, (4) assault, and (5) battery. After Applicant filed suit several of the responsible employees were terminated by Defendant. Applicant ultimately settled his civil case against Defendant for the sum of $600,001, apportioned $36,000 for lost wages, $64,000 for general damages, and $500,001 as payment for damages resulting from physical injuries and emotional distress. Applicant expressly reserved his right to pursue his workers' compensation case.

Applicant also filed a workers' compensation claim alleging that he suffered a specific injury on 7/14/2005. Defendant subsequently sought a credit in Applicant's workers' compensation case under Labor Code §§3600(b), 3602(b)(1), and 4909, based on Applicant's settlement recovery in the civil case. After a trial, the WCJ concluded that Defendant was not entitled to a first-party credit for Applicant's civil settlement, because: (1) the statutory right to credit under Labor Code § 3600(b) for a civil recovery obtained in tort action brought by an injured employee against his or her employer for willful assault by the employer pursuant to the exclusive remedy exemption in Labor Code § 3602(b)(1) does not apply to actions protecting an employee's fundamental civil right to a workplace free of sexual harassment and discrimination under the Fair Employment and Housing Act (FEHA) (Government Code § 12900 et seq.), which is independent of the WCAB, as described in Shoemaker v. Myers (1990) 52 Cal. 3d 1, 276 Cal. Rptr. 303, 801 P.2d 1054, 55 Cal. Comp. Cases 494, (2) Applicant's FEHA claim in this case was not a claim for willful physical assault under Labor Code § 3602(b) because the physical assault was not an isolated event, but rather one event in a pattern of ongoing conduct perpetrated against Applicant over a five-month period, and Applicant's civil pleading of assault did not bring the claim within the statutory credit rights in Labor Code §§ 3600(b) and 3602(b); (3) Applicant's civil settlement release expressly reserved Applicant's right to pursue workers' compensation benefits, and Defendant did not reserve the right to seek credit in the workers' compensation case; (4) because Applicant's claim for damages in the civil action was a claim under FEHA and not a claim for willful physical assault under Labor Code § 3602(b)(1), Defendant's right to credit required proof of overlap between Applicant's civil recovery and his workers' compensation benefits; (5) there was no evidence, based on allocation of the settlement funds, that the recovery received in Applicant's civil suit directly overlapped with Applicant's expected workers' compensation benefits; and (6) the statutory right to credit under Labor Code §§ 3600(b) and 3602(b) is different from the equitable, non-statutory right to credit, which focuses only on disallowing double recovery. Defendant sought reconsideration.

WCAB rejected defendant's attempt to attribute all of applicant's injury to single assault on 7/14/2005 and, instead, found that applicant's injuries arose from defendant's course of conduct during five-month period of applicant's employment, which violated applicant's fundamental civil right to workplace free of sexual harassment and discrimination under Fair Employment and Housing Act, that applicant's civil pleading of assault did not bring claim within statutory credit rights in Labor Code §§ 3600(b) and 3602(b), and that defendant was not civilly liable for specific injury incurred by applicant as result of assault on 7/14/2005 because it was not direct participant in assault nor did it ratify assault, and was, therefore, not entitled to credit pursuant to Labor Code § 3602(b)(1); WCAB also rejected defendant's claim for credit under Labor Code § 4909, when WCAB reasoned that it was defendant's own wrongful

behavior in violation of Fair Employment and Housing Act that led to applicant's injury, and that defendant should not benefit from its own misconduct. Writ Denied.

XIII. Temporary Disability

Ortega, v. City of Guadalupe, PSI, adjusted by York Risk Services Group, Inc., 2016 Cal. Wrk. Comp. P.D. LEXIS 163 (BPD)

Applicant sustained successive industrial injuries to his back and his psyche while working as a police officer on multiple dates of injury. Defendant initially denied liability for applicant's injuries, but later accepted the injuries as Industrial, following the receipt of medical reporting. While seeking workers' compensation benefits, applicant continued to work until applicant was placed on paid administrative leave on May 14, 2013 through February 26, 2014, when applicant's employment ended. The parties obtained a report from an Agreed Medical Evaluator (AME) in March of 2014 who found that applicant was temporarily totally disabled on a retroactive basis. In adjusting applicant's retroactive temporary disability, defendant took full credit for the administrative leave, which defendant paid to applicant and paid temporary disability to applicant beginning February 27, 2014, and continuing through to the 104 week cap on benefits. The issue at trial was defendants right to credit for administrative leave period as against the 104 week cap.

> *". . . Defendant carries the burden of proof upon seeking credit, (Lab. Code, § 5705.) In this case, defendant paid wages to applicant while applicant was suspended on administrative leave. Defendant is entitled to receive a credit for the wages that applicant earned while on temporary disability. (Lab. Code, § 4657.) Applicant received full wages from May 14, 2013, through February 26, 2014; thus, defendant is not required to pay temporary disability benefits during those dates.*
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> *Defendant seeks to retroactively convert administrative leave wages paid to applicant from July 29, 2013, through February 26, 2014, into temporary disability benefits paid and to credit those temporary disability benefits against the 104 week cap on benefits due. However, by paying administrative leave benefits, applicant was, in effect, working during this time period. The fact that the AME retroactively determined that applicant should have been on a period of temporary disability does not change the fact that applicant actually earned wages during this period. Defendant cannot convert wages earned into a credit for disability paid. . ."*
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> *Ortega, v. City of Guadalupe, PSI, adjusted by York Risk Services Group, Inc., 2016 Cal. Wrk. Comp. P.D. LEXIS at pg. 164 (BPD).*
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> *See also, accord in part, Yonemitsu v. Pacific Bell Telephone Co., 2016 Cal.Wrk. Comp. P.D. LEXIS 363, holding defendant/employer has burden of proving that payments under the employer's disability plan where clearly intended by both employer and employee as an advance on compensation to become due.*

The WCJ held that Defendant was not entitled to credit against 104 week cap for payments of administrative leave benefits, as applicant was actually earning wages, despite opinion of agreed medical examiner who determined that applicant was TD during administrative leave period, although defendant was entitled to credit as against TD owed during this period. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 7.04[9][b]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, § 6.19; Sullivan On Comp, 9.31, Temporary Disability – Credit of Wages]

Rogers v. American Medical Response, Ace American Insurance Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 521(BPD).

Defendant was paying temporary disability indemnity based upon the opinion of the PTP. On September 22, 2014 the PTP evaluated the applicant but did not serve a report regarding this evaluation until March 5, 2015. Defendant continued paying temporary disability indemnity until December 12, 2014, when it had paid 104 weeks of temporary disability indemnity. Defendant sought a credit for temporary disability overpayment for the period from 9/22-12/12/14. The WCAB award credit during the period but at the PD rate. Defendant sought reconsideration.

In upholding the WCJ, the WCAB held that the defendant was entitled to credit against permanent disability for overpaid temporary disability indemnity advances, but only at lower permanent disability rate. The WCAB highlighted although the report was not served by evaluating physician for over five months after evaluation, no evidence existed in the record that defendant took any steps to accelerate issuance of report, or that applicant acted in bad faith in accepting temporary disability indemnity benefits during overpaid period. Rogers v. American Medical Response, Ace American Insurance Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 521(BPD); See also, accord, and holding Credit for TD

overpayment within discretion of WCAB, Herrera v. WCAB (1969) 71 Cal.2d 254, 258, 34 Cal.Comp.Cases 382; and Cordes v. Gerneral Dynamics-Astronautics (1966) 31 Cal.Comp.Cases 429 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 7.04[9][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, § 6.19[1]. Sullivan on Comp, Section Section 9.30, Credit for Overpayment of TD.

Work Comp Index
Updates 2018

The following are cites added to the 2018 Work Comp Index, A Topical Guide to The Law of California Workers' Compensation. The Author selected each for either explaining, expanding or resolving a legal doctrine or issue relevant to the Law of California Workers' Compensation. Parallel and Companion cites are provided where available to assist the reader with an understanding of the issue or statement of law involved.

Practitioners should proceed with caution when citing to this panel decision and should also verify the subsequent history of the decision. WCAB panel decisions are citable authority, particularly on issues of contemporaneous administrative construction of statutory language [see Griffith v. WCAB (1989) 209 Cal. App. 3d 1260, 1264, fn. 2, 54 Cal. Comp. Cases 145]. However, WCAB panel decisions are not binding precedent, as are en banc decisions, on all other Appeals Board panels and Workers' Compensation Judges [see Gee v. Workers' Comp. Appeals Bd. (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cases 236]. While WCAB panel decisions are not binding, the WCAB will consider these decisions to the extent that it finds their reasoning persuasive [see Guitron v. Santa Fe Extruders (2011) 76 Cal. Comp. Cases 228, fn. 7 (Appeals Board En Banc Opinion)]. Panel Decisions which are designated as "Significant" by the WCAB, while not binding in Workers Compensation proceedings, are intended to augment the body of binding appellate court and en banc decision and is limited to panel decisions involving (1) issue(s) of general interest to the workers' compensation community, especially a new or recurring issue about which there is little or no published case law; and (2) upon agreement en banc of all commissioners on the significance and importance of the issues presented and resulting decisions. (See Elliot v. WCAB (2010) 182 Cal.App. 4th 355, 361, fn. 3, 75 CCC 81; Larch v. WCAB (1999) 64 CCC 1098, 1099-1100 (writ denied).

Entries For 2018 Edition of Work Comp Index

Contribution-Elections By Employee-Discovery-rejected co-defendant assertion that deposition testimony and reports of AME obtained before co-defendant became party-defendant as improperly admitted into evidence in contribution proceeding in violation of due process rights noting that co-defendant had ample opportunity to conduct discovery prior to Arbitration. Prajapati v. Vesta Intermediate Funding, Inc., 2016 Cal.Wrk.Comp. P.D. LEXIS 382 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 26.01[2][c], 31.13[2][a], [e]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1][d][v], Ch. 15, § 15.15.]; Sullivan on Comp, Section 5.8 Contribution Among Defendants.

Contribution-Burden of Proof- holding that the defendant seeking contribution meet burden of proof by producing Compromise and Release agreement, medical record as it exists, deposition of applicant, and proof of payments, than burden shifts to party opposing contribution to raise issues and provide evidence to defeat or reduce contribution entitlement. Prajapati v. Vesta Intermediate Funding, Inc., 2016 Cal.Wrk.Comp. P.D. LEXIS 382 (BPD; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 31.13[2][a], [e]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1][d], Ch. 15, § 15.15.]; Sullivan on Comp, Section 5.8, Contribution Among Defendants.

Psychiatric Injury-Six-Month Employment Requirement-Sudden and Extraordinary Employment Conditions-Jumping to avoid a large wrecking ball when cable holding snapped held "sudden and extraordinary under LC 3208.3(d) as exception to six-month rule. Docena v. Layner Christensen Co., 2016 Cal.Wrk. Comp. P.D. LEXIS 393; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.02[3][d]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[3][c].]; Sullivan on Comp, Section 5.31, Psychiatric Injury -- Six Month Rule.

Medical Treatment-Independent Medical Review-Appeals--New IMR determination ordered pursuant to Labor Code § 4610.6(i), when WCAB found that UR determination was result of plainly erroneous express or implied finding of fact as matter of ordinary knowledge based on information submitted for review where IMR reviewer erroneously applied Medical Treatment Utilization Schedule (MTUS) guideline. McAtee v. Briggs & Pearson Construction, 2016 Cal.Wrk.Comp. P.D. LEXIS 375 (BPD); But see, contra, Favila v. Arcadia Health Care, Cypress Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 181 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.11.]; Sullivan on Comp, Section 7.41, Independent Medical Review.] But see contra, Nickerson v. Pot Belly Deli, 2016 Cal. Wrk. Comp. P.D. LEXIS 329, and De Lopez v. Facey Medical Foundation 2016 Cal. Wrk. Comp. P.D. LEXIS 423, holding

that the choice of which medical treatment guidelines should apply is a matter of ordinary knowledge and not subject to expert opinion.

Medical Provider Networks-Access Standards-Primary Treating Physicians-WCAB panel majority found that because applicant sought specialist in orthopedic surgery to be his primary treating physician, defendant's MPN need only meet 30 mile/60 minute access standard for selection of specialist under 8 Cal. Code Reg. § 9767.5(a)(2) and not 15 mile/30 minute access standard applicable to selection of primary treating physician under 8 Cal. Code Reg. § 9767.5(a)(1); Luna v. The Home Depot, 2016 Cal. Wrk. Comp. P.D. LEXIS 405 (Split BPD); Puente v. Napa Valley Unified School District, PSI, 2017 Cal. Wrk. Comp. P.D. LEXIS 100 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[4].]; Sullivan on Comp, Section 7.53, Medical Provider Network – Establishment and Maintenance.

Medical Provider Networks-Second Opinion Process- Defendant held not liable for lien of non-MPN treatment as no evidence of denial of care, and after release from further medical care with no work restrictions or need for further medical treatment by MPN treater, applicant was limited to MPN procedures pursuant to Labor Code § 4616.3 or med-legal procedures pursuant to Labor Code §§ 4061 and 4062. Morales v. Pro Armor, 2016 Cal.Wrk.Comp. P.D. LEWIS 378 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[8][b].]; Sullivan on Comp, Section 7.55, Medical Provider Network – Dispute Resolution.

Credit-Employer Benefit Plan-Defendant/employer has burden of proving that payments under the employer's disability plan where clearly intended by both employer and employee as an advance on compensation to become due. Yonemitsu v. Pacific Bell Telephone Co., 2016 Cal.Wrk. Comp. P.D. LEXIS 363; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 7.04[9][b]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, § 6.19[2].]; Sullivan on Comp, Section 9.32, Credit for Payment of Benefits.

Permanent Disability-Offer of Regular, Modified or Alternative Employment- Neither Applicant entitled to 15 percent increase nor defendant to 15% decrease pursuant to LC 4658(d) where applicant returned to regular work prior to P&S, lost no further time upon return to work and therefore defendant needed no incentive to return applicant to work; Thus, the purpose of LC 4658(d) to provide economic incentive to employers to return applicant to regular work would not be served. Tillman v. State of California, Corrections & Rehabilitation Parole, 2016 Cal.Wrk.Comp. P.D. LEXIS 386; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 7.02[4][d][iii], 32.04[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, § 7.51[2].]; Sullivan on Comp, Section 11.6, Adjustment of Permanent Disability Payments for Offer of Work.

Medical-Legal Procedure-Assignment and Selection of Panel Qualified Medical Evaluators-Specialty Designation-Where applicant properly and timely requested chiropractic panel pursuant to procedure in Labor Code § 4062.2, complied with requirements of 8 Cal. Code Reg. § 30 by indicating that qualified medical evaluator panel was per LC 4600 attaching copy of defendant's denial letter, specialty not invalidated simple because specialty selected different from specialty of her treater, where defendant waived objection to panel by failing to submit written objection to Medical Director asking for review of panel assignment as required under 8 Cal. Code Reg. § 31.5(a)(10); Objection letter to applicant's counsel held insufficient. Lopez v. California Pizza Kitchen, 2016 Cal. Wrk. Comp. P.D. LEXIS 399 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§1.11[3][g], 22.06[1][a], 22.11[2], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[2], Ch. 19, § 19.37.]; Sullivan on Comp, Section 14.29, Medical-Legal Process – Representing Employee.

Medical-Legal Procedure—Qualified Medical Evaluators—New Injuries—QME is required to address all medical issues, including dates of injury holding that Navarro requires that the same qualified medical evaluator is required to address all contested medical issues arising from all injuries reported on one or more claim forms filed prior to initial qualified medical evaluation. Parker v. DSC Logistics, Zurich North

America, 2016 Cal. Wrk. Comp. P.D. LEXIS 402; 82 Cal. Comp. Cases 105, (BPD); Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418 (Appeals Board en banc opinion); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 22.11[11]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[11]; Sullivan on Comp, Section 14.52 Subsequent Evaluations and Additional QME Panels in Different Specialties.]

Medical-Legal Procedure-Additional Medical Evaluations- Applicant who suffered admitted industrial back injury may obtain additional qualified medical evaluator panels pursuant to 8 Cal. Code Reg. § 32.6, where continuing complaints regarding neurological symptoms and sexual dysfunction outside PTP's expertise, and that although generally parties should obtain opinion of primary treating physician prior to seeking additional qualified medical evaluator panels for different body parts, treating physician's opinion is not mandatory. Vera v. Monsanto Company, PSI, adjusted by Sedgwick Claims Management Services, 2016 Cal. Wrk. Comp. P.D. LEXIS 360 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 22.11[9]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[9]; Sullivan on Comp, Section 14.52 Subsequent Evaluations and Additional QME Panels in Different Specialties.]

WCAB Procedure-Declarations of Readiness to Proceed-Objections-Defendant's failure to object to DOR constitutes a waiver of all objection which may have been made and allowed applicant to proceed to trial solely on report of PTP without LC 4061 medical-legal report citing Rule 10416. Orellana v. Pro Wash, Inc., State Compensation Insurance Fund, 2016 Cal. Wrk. Comp. P.D. LEXIS 401 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 25.08[2], 26.03[4], 32.06[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, §§ 15.03[2], 15.41[2], Ch. 16, § 16.51[6], Ch. 19, § 19.37. Sullivan on Comp, Section 15.17, Declaration of Readiness to Proceed].

Alternative Dispute Resolution-Transfer of Medical Treatment-By split panel opinion, applicant who suffered CT ending 1/22/14 and was treating outside of alternative dispute resolution agreement based on denial of her claim by defendant, was required to transfer treatment to ADR agreement's exclusive provider network after defendant accepted her claim, pursuant to provisions in Labor Code § 3201.5 and terms of ADR agreement. But See, well-reasoned dissenting opinion of Commissioner Sweeney. Farias v. Able Building Maintenance, Zurich North America, 2016 Cal. Wrk. Comp. P.D. LEXIS 440 (Board Panel Decision). [See generally Hanna. Cal. Law of Emp. Inj. and Workers' Comp. 2d § 1.04A; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, § 3.04[3]; Sullivan on Comp, Section 3.5, Carve-Outs]

Insurance Coverage-Cancellation of Policy-Insurer not permitted to retroactively rescind workers' compensation insurance policy for fraud where employer misrepresented that its truck drivers did not travel outside State of California; Rather insurer may seek retroactive rescission/cancellation by way of declaratory relief action in Superior Court, but insurer would be required to provided WC benefits during pendency of Declaratory relief action. Berrios v. El Distribution Corp, 2016 Cal.Wrk.Comp. P.D. Lexis 416; Insurance Code Section 676.8. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 2.13, 2.61[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, § 3.24[2]. Sullivan on Comp, Section 3.9, Cancellation of Insurance]

Presumption of Industrial Causation-Heart Trouble-Peace Officers- Safety officer held entitled to LC 3212.5 heart presumption despite prior cardiovascular condition as he did not develop hypertrophic cardiomyopathy until well into his employment and the WCAB found this heart trouble developed or manifested while he was in the service of the sheriff department. Further, because LC 3212.5 presumption applies the PD was not subject to apportionment pursuant to LC 4663(e). Simmons v. County of Riverside, 2016 Cal.Wrk.Comp. P.D. LEXIS 442 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.138[4][f]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.07[3], [5][b]. Sullivan on Comp, Section 5.17, Presumption of Injury.]

Liens-Procedural Rights and Duties-Statute of Limitations-18 month statute of limitation pursuant to 4903.5(a) effective 1/1/13 applies to bar lien claim even though some services were provided before 7/1/2013, where lien claimant had reasonable time after effective date within which to timely file its lien,

and filing nearly two years after last date services. Miranda v. El Super Market, 2016 Cal..Wrk.Comp. P.D. LEXIS 434; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§30.04[8][a], 30.20[1], 30.21, 30.24; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, §§ 17.110[2], [3], 17.111[3], [5].]

Medical Provider Networks-Utilization Review-An injured worker within an MPN may dispute a diagnosis or treatment recommendations by MPN treating physician by submitting the dispute to MPN IMR, (e.g. second opinion process provided in Labor Code section 4616.3, or change treating physicians within the MPN); but MPN dispute process in Labor Code § 4616 et seq. is not available to employer/insurer, and only available method for employer/insurer to dispute treatment recommendations is through UR/IMR process. Parrent v. SBC-Pacific Bell, 2016 Cal. Wrk. Comp. P.D. LEXIS 437 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]; Sullivan on Comp, Section 7.55, Medical Provider Network – Dispute Resolution]

Permanent Disability-Rating-Combined Values Chart-WCJ improperly added rather than combining despite the fact that QME testimony at deposition was that the impairment for different parts of the spine should be added because they involve "two different parts of the spine" without further explanation as to the "how and why" addition of the impairments is more accurate than combination using CVC, and thus did not constitute substantial evidence. Leo v. Greenspan Adjusters International, Inc., 2016 Cal.Wrk.Comp. P.D. LEXIS 431 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4][a], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA Guides and California Workers' Compensation, Ch. 6.]

Credit-Overpayment of Temporary Disability-Defendant was entitled to credit for TD overpayment pursuant to Labor Code § 4909 against PD were defendant properly paid temporary disability benefits in accordance with medical evidence it had at time payments were made, that absence of wrongdoing on applicant's part is not necessarily determinative factor on issue of whether credit is allowed, and here the amount of credit will have a minimal impact on the overall award and thus minimal hardship in applicant. - Leo v. Greenspan Adjusters International, Inc., The Hartford, 2016 Cal. Wrk. Comp. P.D. LEXIS 431(BPD); But see, conta but distinguishable, J.C. Penny v. WCAB (Edwards) (2009, 3rd Appellate District) 175 Cal.App.4th 818, 37 CWCR 141, 74 CCC 826, credit disallowed for failure to object; accord Jones v. Tulare District Hospital 2014 Cal.Wrk.Comp.P.D. LEXIS 593 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 7.04[9][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, § 6.19[1].]

Permanent Disability-Apportionment-AME apportionment opinion constituted substantial where the AME explained how applicant suffered significant depression following death of his son and that applicant's current disability was actually caused by aggravation of his preexisting depression; It is responsibility of each medical evaluator to determine apportionment for body parts or systems within his or her area of expertise and should not simply mirror apportionment opinions of other doctors. Kubeck v. Caletti Jungsten Construction, American Zurich Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 430 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[1]-[3], 8.07, 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.40[1], 7.42[1], [2], [4]; The Lawyer's Guide to the AMA Guides and California Workers' Compensation, Chs. 9, 10; Sullivan on Comp, Section 10.34, Apportionment – Pre-Existing Disease or Conditions]

Injury AOE/COE-Substantial Evidence-Diabetes-Applicant's toe amputation was compensable industrial injury based on treating physician's opinion that amputation was necessary due to applicant's working related activity, and treater's opinion found more persuasive than opinion of panel qualified medical. Abrego v. Harland Braun & Company, State Compensation Insurance Fund and Everest National Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 387 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 4.05[2][a], [d], [3][a], 27.01[1][c]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.01[4]

Supplemental Job Displacement Benefits——Settlement—Thomas Findings—A party may be settled his or her potential right to Supplemental Job Displacement Benefit voucher in Compromise and Release when there exist a serious and good faith issue which, if resolved against injured worker, would defeat all of his or her rights to compensation benefits. Beltran v. Structural Steel Fabricators, State Compensation Insurance Fund, Defendants, 2016 Cal. Wrk. Comp. P.D. LEXIS 366; 81 Cal. Comp. Cases 1224, (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 29.02[3][b], 35.01; Rassp & Herlick, California Workers' Compensation Law, Ch. 21, § 21.01.]

Statute of Limitations—Cumulative Injuries—Professional Athletes—Labor Code § 5405(a) statute of limitations, was tolled where defendant failed to give applicant notice of his workers' compensation rights as required under Reynolds v. W.C.A.B. (1974) 12 Cal. 3d 726, 117 Cal. Rptr. 79, 527 P.2d 631, 39 Cal. Comp. Cases 768, despit evidence that applicant had basic and general knowledge of his workers' compensation rights inferred from previous claim of specific injury. Miami Dolphins, Ltd., Multi-Line Claims Services v. Workers' Compensation Appeals Board, (Delvin Williams) 81 Cal. Comp. Cases 816; 2016 Cal. Wrk. Comp. LEXIS 99 (Writ of Review Denied); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 24.03[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 14, §§ 14.13[1], 14.16.]

Petitions to Reopen-Change in Disability Status-WCAB Jurisdiction- Despite applicant's timely file petition to reopen, the WCAB lacked jurisdiction, under Labor Code § 5804 to issue award which reduced applicant's permanent disability when no petition to reduce permanent disability was timely filed by defendant within five years of date of injury. Weitnauer v. Sacramento County Sheriff's Department, Defendant (BPD) 2016 Cal. Wrk. Comp. P.D. LEXIS 17, [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 31.04[2][b], [3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 14, §§ 14.04, 14.06[2].]

Injury AOE/COE-Commission of Felony- split panel held that under strict interpretation of language in Labor Code § 3600(a)(8), "conviction" of felony is required to bar workers' compensation claim under this provision, and that under Georgia law (where injury occurred and criminal felony charges originated), "conviction" requires final judgment of conviction to be entered upon verdict or finding of guilt of crime or upon guilty plea, that in view of deferral of applicant's prosecution after finding of guilt by superior court pursuant to Georgia's First Offender law (Ga. Code Ann. § 42–8-60), requirement that applicant's injury be caused by commission of felony for which she was "convicted" was not met in this case, and that because applicant was not "convicted" of felony, her claim was not barred by Labor Code § 3600(a)(8). Schwartz v. Ease Entertainment, Starr Indemnity and Liability Company (BPD) 2016 Cal. Wrk. Comp. P.D. LEXIS 106; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 30.08; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.85.].

Statute of Limitations—Cumulative Injuries—Professional Athletes—professional baseball pitcher's claim of cumulative injury for period ending 2004, filed 2013 was barred by one-year statute of limitations in Labor Code § 5405, where applicant knew or should have known of his right to file workers' compensation claim and suffered disability for purposes of Labor Code § 5412 date of injury more than one year before claim was filed, based on evidence that (1) applicant had actual knowledge of his right to seek workers' compensation benefits evidenced by 2007 claim; and (2) applicant's testimony that he made correlation between his orthopedic symptoms forcing retirement and his employment as professional baseball player; and statute of limitations not tolled by defendants' failure to provide applicant with actual notice of his workers' compensation rights pursuant to Reynolds v. W.C.A.B. (1974) 12 Cal. 3d 726, 117 Cal. Rptr. 79, 527 P.2d 631, 39 Cal. Comp. Cases 768, where no evidence such as medical records/reports or team records indicating that defendants knew of applicant's cumulative injury. Estrella v. Milwaukee Brewers and San Francisco Giants (W/D) 81 C.C.C. 525; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 24.03[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 14, §§ 14.13[1], 14.16.]

California Insurance Guarantee Association-General and Special Employment-Restricting and Limiting Endorsements-To properly exclude liability through limiting and restricting endorsement, the insurer is required to show that it received approval to use endorsement from Insurance Commissioner, that special employer entered into valid and enforceable Labor Code § 3602(d) agreement with general employer, and

that general employer obtained workers' compensation coverage for excluded employees. It is the insurer asserting the limiting and restricting endorsement has the burden of showing endorsement was approved by Insurance Commissioner. Corona v. Koosharem, 2016 Cal. Wrk. Comp. P.D. LEXIS 542 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§2.60[3], 2.84[3][a], 3.142[5]; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, §§ 3.30[2], 3.33[3]. Sullivan on Comp, Section 3.47, California Insurance Guarantee Association – Coverage Limitations]

Employment Relationships-Existence of Employment Contract-Consideration-Applicant held not employee where no express or implied agreement for applicant to perform work in exchange for consideration of free rent due to conflicting evidence in record regarding nature of relationship between parties. Garcia v. Whitney, 2016 Cal.Wrk.Comp.P.D. LEXIS 526 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d ß 3.21[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 2, ß 2.01[1]. Sullivan on Comp, Section 4.7, Employee – Under Contract of Hire]

Injury AOE/COE—Going and Coming Rule—Required Vehicle Exception—Applicant within course and scope of employment during bicycle commute between two clients' homes, as employer knew applicant provided care to more than one home each day, employer impliedly required the applicant to provide her own transportation which provided a direct benefit to employer, and was 'part and parcel' of job. Zhu v. Workers' Compensation Appeals Board (2nd Appellate District) 12 Cal. App. 5th 1031; 82 Cal. Comp. Cases 692; 2017 Cal. App. LEXIS 564; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.155[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.05[3][d][ii]. Sullivan on Comp, Section 5.45, Transportation Controlled by Employer]

Liens—Procedural Rights and Duties—Statute of Limitations—Lien filed by lien claim held not barred by three-year statute of limitations in Labor Code § 4903.5(a), as amendments to Labor Code § 4903.5 effective on 1/1/2013 do not apply retroactively as no express legislative language of retroactivity. De La Luz Garcia v. Morton Manufacturing, 2016 Cal. Wrk. Comp. P.D. LEXIS 480 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 30.04[8][a], 30.20[1], 30.21; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.111[3], [5]. Sullivan on Comp, Section 6.51, Statute of Limitations for Filing Lien.]

Medical Treatment—Utilization Review—Physical Therapy—When treating physician submits RFA for medical treatment, the UR Physician, not claims adjuster, is required to apply MTUS to determine medical necessity of proposed treatment, and that since application of MTUS post-surgical guidelines was required to determine whether additional physical therapy visits were medically necessary to treat applicant's injury, it was beyond claims adjuster's authority to apply MTUS to deny treating physician's RFA, and RFA should have been submitted to UR for review by licensed physician. Lambert v. State of California Department of Forestry, 2016 Cal. Wrk. Comp. P.D. LEXIS 492 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][a], [b], 22.05[6][b][i], [ii]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10[6]. Sullivan on Comp, Section 7.22, Statute of Limitations on Therapy]

Liens—Medical—Burden of Proof—A claim on delay pursuant to Labor Code § 5402(c) requires employer to provide applicant with reasonable and necessary medical treatment until claim is either accepted or rejected, and lien claimant is not required to establish that applicant's alleged injuries for which treatment was provided were industrial to recover its lien for treatment under Labor Code § 5402(c). De La Luz Garcia v. Morton Manufacturing, 2016 Cal. Wrk. Comp. P.D. LEXIS 480 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.07[3][a], 30.25[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4 § 4.03[2], [3]. Sullivan on Comp, Section 7.24, Duty to Provide Care Proactively]

Medical Treatment-Utilization Review-Role of Agreed Medical Examiner--Board held that an agreement between the parties to resolve a single medical issue through the use of an AME pursuant to LC 4062(b) cannot be used to avoid application of the UR/IMR process pursuant Labor Code §§ 4610 and 4610.5. Garcia v. American Tire Distributors, Broadspire, 2016 Cal. Wrk. Comp. P.D. LEXIS

527 (BPD); But see contra, Payne v. Federal Express, PSI, and Administered by Broadspire, 2017 Cal. Wrk. Comp. P.D. LEXIS 243 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11. Sullivan on Comp. Section 7.36, Utilization Review -- Procedure]

Medical Provider Networks—Utilization Review—Sanctions— Administrative Director Rules 9785(g) and 9792.6.1(t)(2) require the RFA to include documentation substantiating the need for the requested treatment. It is the primary treating physician, and not a claims adjustor, who knows what medical records substantiate the requested treatment. Therefore, the defendant's failure to take the initiative and submit applicant's complete medical record to the UR doctor will not constitute a bad faith tactic that is frivolous or solely intended to cause delay justifying the impositions of 5813 sanctions. McKinney v. Enterprise Rent-A-Car of San Francisco, 2016 Cal. Wrk. Comp. P.D. LEXIS 495 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][f], 22.05[6][b][v], 23.15; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10, Ch. 16, § 16.35[2]. Sullivan on Comp, Section 7.34 Utilization Review – Requests for Authorization]

Medical Provider Networks—Utilization Review—Independent Medical Review— RFA from MPN treating physician is subject to UR/IMR process, which is consistent with the legislative goal of assuring that medical treatment is provided by all defendants consistent with uniform evidence-based, peer-reviewed, nationally recognized standards of care; Commissioner Sweeney concurring separately noted two separate statutory tracks to dispute recommendation of MPN treating physician, consisting of UR IMR (employer objects) and second opinion MPN IMR process (employee objects); Hogenson v. Volkswagen of America, Insurance Company of the State of Pennsylvania, 2016 Cal. Wrk. Comp. P.D. LEXIS 488 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]. Sullivan on Comp, Section 7.55, Medical Provider Network – Dispute Resolution]

Medical-Legal Procedure—Assignment and Selection of Panel Qualified Medical Evaluators—Specialty Designation—Dispute over appropriate qualified medical evaluator specialty must first be submitted to Medical Director as required by 8 Cal. Code Reg. § 31.5(a)(10), and 31.1(b) applicable rules do not permit parties to bypass requirement that qualified medical evaluator specialty disputes "shall be resolved" by Medical Director, and that it was improper for WCJ to issue determination without first directing parties to submit dispute to Medical Director. Portner v. Costco, Liberty Mutual Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 499 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[2], [4], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[2], [4], Ch. 19, § 19.37. Sullivan on Comp, Section 14.29, Medical-Legal Process]

Medical-Legal Procedure—Qualified Medical Evaluators—New Injuries—Claim form alleging DOI prior to date of QME examination set on previously filed injuries, but filed subsequent to date of QME examination, held applicant allowed a new QME as the date of injury under LC 4062.3(j) and LC 4064(a) is the date the claim form was filed with the employer pursuant to LC 5401 interpreting Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418 (Appeals Board en banc opinion). WCAB rejected defendant's suggestion that applicant intentionally delayed filing claim for 9/25/2015 injury until after initial evaluation in order to obtain another panel qualified medical evaluator because there was no evidence to support defendant's assertion. Hernandez v. Ramco Enterprises, PSI, 2016 Cal. Wrk. Comp. P.D. LEXIS 486 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 22.11[11]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[11]. Sullivan on Comp, Section 14.52, Subsequent Evaluations and Additional QME Panels in Different Specialties.]

Medical-Legal Procedure-Assignment of Qualified Medical Evaluator Panel to Evaluate Permanent Disability-Different Specialty-Matter dropped from calendar despite no objection by Defendant to applicant's DOR as Labor Code § 4061(i), as amended by SB 863, expressly requires evaluation by agreed or qualified medical evaluator before parties can file declaration of readiness to proceed on issue of permanent disability, and no waiver by Defendant because Labor Code § 4061contains no specific time limits for objection to treating physician's permanent disability findings, and defendant acted reasonably

and timely in medical legal process. Ventura v. The Cheesecake Factory, Zurich American Insurance Company, 2014 Cal. Wrk. Comp. P.D. LEXIS 417 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], [2], 22.11[7], 26.03[4], 32.06[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[2], Ch. 16, § 16.54[7]. Sullivan on Comp, Section 15.17, Declaration of Readiness to Proceed]

Dismissal-Failure to Appear-Accommodation Requirements-Dismissal without prejudice rescinded where when medical reports established diagnosis of agoraphobia and panic disorder and applicant was medically unable to appear in court; Due process required accommodations such as being permitted to appear telephonically or via Skype. Gonzalez v. Imperial County Office of Education, 2016 Cal. Wrk. Comp. P.D. LEXIS 528 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 26.01[3][b], 26.04[1][c]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.07[2][b]. Sullivan on Comp, Section 15.37, Requirement to Appear at Hearing.]

Hearings—Attendance of Witnesses—Error for WCJ to order former counsel to attend hearing as witness rather than by subpoena pursuant to Cal. Code Civ. Proc. § 1985, and the subpoena must be personally served as required by Cal. Code Civ. Proc. § 1987. Williams v. Department of Corrections & Rehabilitation, 2016 Cal. Wrk. Comp. P.D. LEXIS 511(BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 25.10[2][a], 26.03[4], 26.05[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1], Ch. 16, § 16.48[1], Ch. 19, § 19.37. Sullivan on Comp, Section 15.47, Trial – Proceedings and Submission]

Exclusivity of Remedy—Conditions of Compensation—Industrial Causation.—Civil claim in tort held not barred exclusive remedy defense where employer held mock robbery applying LC 3601/02 assault exception to AOE/COE. Lee v. West Kern Water District, (5th Appellate District) 5 Cal. App. 5th 606; 210 Cal. Rptr. 3d 362; 81 Cal. Comp. Cases 966; 2016 Cal. App. LEXIS 985; [Hanna, Cal. Law of Employee Injuries and Workers' Compensation Law (2016) ch. 11, § 11.02; Levy et al., Cal. Torts (2016) ch. 10, § 10.11; Cal. Forms of Pleading and Practice (2016) ch. 577, Workers' Compensation, § 577.356; Wilcox, Cal. Employment Law (2016) ch. 20, § 20.41. Sullivan on Comp, Section 2.19, Exceptions to Exclusive Remedy Rule for Conduct Outside Compensation Bargain]

Insurance—Duty to Insure—Penalty for Noncompliance—Calendar Year Preceding Determination—Calendar year, as used in Lab. Code, § 3722, subd. (b), means the 12-month period immediately preceding the determination. An employer had a triggering event of uninsurance within that period. Taylor v. Department Of Industrial Relations, Division Of Labor Standards Enforcement, (1st Appellate District) 4 Cal. App. 5th 801; 208 Cal. Rptr. 3d 728; 81 Cal. Comp. Cases 1016; 2016 Cal. App. LEXIS 912; [Hanna, Cal. Law of Employee Injuries and Workers' Compensation Law (2016) ch. 2, § 2.17; Herlick, California Workers' Compensation Law (7th ed. 2015) ch. 3, § 3.19; Cal. Forms of Pleading and Practice (2016) ch. 577, Workers' Compensation, § 577.13; 2 Witkin, Summary of Cal. Law (10th ed. 2005) Workers' Compensation, § 150 et seq.; Sullivan on Comp, Section 3.38, Penalties Against Uninsured Employers – Civil Penalties]

California Insurance Guarantee Association-Other Insurance-Insurance Provided by State- defendant California Department of Social Services/In-Home Supportive Services, as legally uninsured entity, did not constitute "other insurance" pursuant to Insurance Code § 1063.1(c)(9) as the State of California is not required to purchase workers' compensation insurance or secure certificate of self-insurance pursuant to Labor Code § 3700. Nunez v. Mann Packing Company, Inc., CIGA, 2016 Cal. Wrk. Comp. P.D. LEXIS 568 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 25.40, 25.43, 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45, Ch. 19, § 19.37. Sullivan On Comp, Section 3.47, CIGA – Coverage Limitations]

Statute of Limitations-Specific Injury Claims- WCAB held that Application for Adjudication involving unresolved psychiatric component of injury file within one year of furnishing of treatment was timely file and not barred under Labor Code § 5405; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 24.03[1], 24.04[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 14, § 14.15.]

Medical Provider Networks-Designation of Treating Physician Within Medical Group-Utilization Review-Applicant may properly select individual physician not individually listed on employer's MPN where physician's medical group is listed, and MPN medical groups employs services of physicians who do not register individually with MPN; WCAB interpreting Labor Code § 4616(a)(3) and 8 Cal. Code Reg. § 9767.5.1. Rivas v. North American Trailer, 2016 Cal. Wrk. Comp. P.D. LEXIS 572 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[2]. Sullivan on Comp, Section 7.53, Medical Provider Network.]

Death Benefits-Partial Dependency-Dependency established where decedent's history of past sporadic actual contributions of support, coupled with his clear intent to resume child support payments to satisfy arrearages, held sufficient to establish that decedent's daughter was partially dependent at time of death. Duboise (Deceased), Department of Industrial Relations Death Without Dependents Unit, Pamela Megan Duboise v. Black Road Auto & Tow, State Compensation Insurance Fund, 2016 Cal. Wrk. Comp. P.D. LEXIS 552 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 9.05[4][d]; Rassp & Herlick, California Workers' Compensation Law, Ch. 9, § 9.12[2]; Sullivan on Comp, Section 12.11, Factual Determination of Dependency].

Workers' Compensation § 113—Law Enforcement Officers—Advance Disability Pension Payments—Compensation.—Advance disability pension payments paid pursuant to LC 4850.4 are compensation, for which the Board has jurisdiction to impose penalties under § 5814 for the unreasonable delay. GAGE v. Workers' Compensation Appeals Board and County Of Sacramento (3RD Appellate District) 6 Cal. App. 5th 1128; 211 Cal. Rptr. 3d 892; 81 Cal. Comp. Cases 1127; 2016 Cal. App. LEXIS 1120; [Hanna, Cal. Law of Employee Injuries and Workers' Compensation Law (2016) ch. 10, § 10.40; Cal. Forms of Pleading and Practice (2016) ch. 577, Workers' Compensation, § 577.243. Sullivan on Comp, Section 13.21, Unreasonable Delay]

Medical-Legal Procedure-Medical Examiner Reporting Timeframes-Initial Medical-Legal Reports-Timely service by fax of QME report on applicant, but not on defendant violates statutory timeframe for completion of initial medical report is 30 days from date of medical evaluation (LC 139.2(j)(1)(A)) where defendant objected to late report before receiving it, , objecting party is entitled to replacement panel under Labor Code § 4062.5 and 8 Cal. Code Reg. Salazar v. San Diego Personnel and Employment Agency, Inc., 2016 Cal. Wrk. Comp. P.D. LEXIS 573 (BPD) (Citing with Approval Corrado v. Aquafine Corporation, 2016 Cal. Wrk. Comp. P.D. LEXIS 318 (Appeals Board noteworthy panel decision)) . [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[4], 22.11[6], [11], [14], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[6], [11], [14]; Ch. 19 § 19.37. Sullivan on Comp, Section 14.42, Timeliness Requirements]

Medical-Legal Procedure-Assignment and Selection of Panel Qualified Medical Evaluators-Replacement Panels-Telemedicine-Replacement panel allowed where original QME could only evaluate the applicant via telemedicine and not face-to-face. Gonzales v. ABM Industries, ESIS, 2016 Cal. Wrk. Comp. P.D. LEXIS 558 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.11[6], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[6], Ch. 19, § 19.37. Sullivan on Comp, Section 14.44, Evaluation Requirements and Rights]

Medical-Legal Procedure-Ex Parte Communication-Preparation and Admissibility of Medical-Legal Report-QME supplemental report held not admissible and defendant not liable for cost where in preparing supplemental report QME reviewed summarized records from E-DATA and failed to disclose that in his report violating Labor Code § 4628(a); Replacement panel on untimely supplemental report is discretionary with WCAB. Gallardo v. AT&T Mobility Services, LLC and Old Republic Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 554 (BPD); Gonzalez v. 3M Company, Old Republic Insurance, 2017 Cal. Wrk. Comp. P.D. LEXIS 64 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.06[3], 22.09[5], 26.06[12][b][i], 30.05[2][d]; Rassp & Herlick, California Workers' Compensation Law,

Ch. 16, §§ 16.03[4][e], 16.51[6], Ch. 17, § 17.72[2]. Sullivan on Comp, Section 14.46, Restrictions Against Ghostwriting Medical-Legal Reports]

Medical-Legal Procedure-Qualified Medical Evaluators-New Injuries-QME required to address all issue as they exist at time of examination including separately pled dates of injury occurring prior to date of examination despite one date of injury denied and one accepted, interpreting Navarro v. City of Montebello (2014) 79 Cal.Comp.Cases 418 (En Banc). Bombardly v. City of Fresno, Sanitation Dept, Risico Claims Management, 2016 Cal. Wrk. Comp. P.D. LEXIS 547 (BPD) injury. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.11[11], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[11], Ch. 19, § 19.37. Sullivan on Comp, Section 14.52, Subsequent Evaluations and Additional QME in Different Specialties]

Negligence—Duty of Care—Asbestos—Take-Home Exposure—California Supreme Court held that in secondary exposure to asbestos cases it is reasonably foreseeable that workers, their clothing, or personal effects will act as vectors carrying asbestos from premises to household members, and employers have a duty under Civ. Code, § 1714, to take reasonable care to prevent this means of transmission. This duty also applies to premises owners, subject to any exceptions and affirmative defenses generally applicable to premises owners; This duty extends only to members of a worker's household because the duty is premised on the foreseeability of both the regularity and intensity of contact that occurs in a worker's home. Kesner v. The Superior Court Of Alameda County (Supreme Court Of California) 1 Cal. 5th 1132; 384 P.3d 283; 210 Cal. Rptr. 3d 283; 81 Cal. Comp. Cases 1095; 2016 Cal. LEXIS 943; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 23.03[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.01[4][c]; Sullivan on Comp, Section 2.30, Civil Claims by Dependents and Other Third Parties.]

Presumption of Industrial Causation—Firefighters—Exposure to Biochemical Substances—The presumption of industrial causation for injury from exposure to biochemical substances in Labor Code § 3212.85 requires that the person using the chemical or hazardous materials as weapons of mass destruction "knowingly utilizes those agents with the intent to cause harm"/use of substance as weapon with intent to cause widespread great bodily injury or death. Davis v. State of California, Department of Forestry and Fire Protection, State Compensation Insurance Fund, 2016 Cal. Wrk. Comp. P.D. LEXIS 611; 82 Cal. Comp. Cases 285 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.138[4][p]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.07[5][g]. Sullivan on Comp, Section 5.18, Presumption of Injury]

Injury AOE/COE-Going and Coming Rule-Special Mission-Motor Vehicle accident not barred by "Going and Coming Rule" where applicant's travel to co-worker's home was not ordinary commute to fixed place of business, was undertaken for employer's benefit and to saved employer costs of reimbursing two separate trips; Discussion on 'Special Mission' exception to 'Going and Coming'. Rowe v. Road Dog Drivers, LLC, Insurance Company of the State of Pennsylvania, 2016 Cal. Wrk. Comp. P.D. LEXIS 622 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.157; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.05[3][d][iv], [8]. Sullivan on Comp, Section 5.48, Special Mission – Special Errand.]

Liens-Medical-Outpatient Surgery Centers-Illegal Referrals- Lien claimant held not entitled to reimbursement for services provided to applicant as barred by Labor Code § 139.31, where referring physician had financial interest in lien claimant and preauthorization was not as required Labor Code § 139.31(i), which was not waive by defendant's partial payment. Estrella v. National Express Corporation, 2016 Cal. Wrk. Comp. P.D. LEXIS 614 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 10.53, 30.04[12] [c][ii]; Rasp & Horlick, California Workers' Compensation Law, Ch. 17, § 17.72[2]. Sullivan on Comp, Section 7.77, Medical Expense – Illegal Conduct.]

Temporary Disability-Rate- TD is payable at maximum rate in effect at time temporary disability payments were actually made pursuant to Labor Code § 4661.5, rather at maximum rate in effect when defendant made payments of temporary disability at incorrect rate, interpreting Labor Code § 4661.5 to mean that when any portion of temporary disability payment is made two years or more from date of injury, payment

must be computed in accordance with rate in effect at time payment is made, citing Hofmeister v. W.C.A.B. (1984) 156 Cal. App. 3d 848, 203 Cal. Rptr. 100, 49 Cal. Comp. Cases 438. Guindon v. Robertson's Ready Mix, 2016 Cal. Wrk. Comp. P.D. LEXIS 615 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 7.04[1], [2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, § 6.08[1], [2]. Sullivan on Comp, Section 9.6, Temporary Total Disability after Two Years.]

Temporary Disability-Post-Retirement Period of Disability-Applicant entitled to temporary disability benefits for post-retirement period of temporary disability citing Gonzales v. W.C.A.B. (1998) 68 Cal. App. 4th 843, 81 Cal. Rptr. 2d 54, 63 Cal. Comp. Cases 1477,where applicant credibly testified that she retired due to effects of her industrial injury, that defendant presented no legal authority for its proposition that there must be medical evidence establishing that industrial injury forced applicant to retire, and that defendant's reliance on applicant's post-injury medical treatment and benefit history was overwhelmingly rebutted by applicant's credible testimony regarding her decision to retire. Castellanos v. County of Kern, County Counsel, 2016 Cal. Wrk. Comp. P.D. LEXIS 632 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 7.01[2], 7.02[4][b]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, § 6.01[1]. Sullivan on Comp, Section 9.27, Temporary Disability for Retired Employees.]

Death Benefits-Conclusive Presumption of Total Dependency-Incapacity-Labor Code § 3501(a) did not support defendant's position that for minor to be entitled to lifetime benefits, his or her physical or mental incapacity must have been established prior to time of accident, and finding that decedent's son became physically and mentally incapacitated at time of industrial accident was sufficient to meet requirements for defendant's liability for lifetime benefits pursuant to Labor Code § 4703.5. Pantus v. Get'er Done Trucking, State Compensation Insurance Fund, 2016 Cal. Wrk. Comp. P.D. LEXIS 619 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 9.05[3][a], [b]; Rassp &.05 Herlick, California Workers' Compensation Law, Ch. 9, § 9.11[3], Sullivan on Comp, Section 12.19, Special Deaths Benefits for Totally Dependent Minor Children.]

Liens-Medical-Exclusion of Evidence-Strict application of 8 Cal. Code Reg. § 10629(d) requiring exhibits be identified and resulting in exclusion of exhibits mading it impossible for a party to prevail, does comport with constitutional mandate to accomplish "substantial justice" or public policy in favor of deciding cases on their merits. Gottlieb v. Kitchen for Exploring Foods, 2016 Cal. Wrk. Comp. P.D. LEXIS 635 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.08[4][a], 26.04[2], 30.22[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.04[1], Ch. 17, § 17.11. Sullivan on Comp, Section 15.28, Mandatory Settlement Conference]

Liens-Procedural Rights and Duties-Hearings-WCJ violated medical treatment lien claimant's due process rights by refusing to allow live testimony of applicant's treating physician at trial, even though treater was listed as witness by lien claimant and appeared at trial, despite CCR 10629(d) prohibition to live medical testimony. Moore v. Sun Health Care, PSI, 2016 Cal. Wrk. Comp. P.D. LEXIS 645 (BPD)
[See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 30.22[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.113.]

Medical Evaluators—Information—Communication— "INFORMATION," as used in Labor Code § 4062.3, constitutes (1) records prepared or maintained by employee's treating physician or physicians, and/or (2) medical and nonmedical records relevant to determination of medical issues; "COMMUNICATION," as used in Labor Code § 4062.3, may constitute "information" if it contains, references, or encloses (1) records prepared or maintained by employee's treating physician or physicians, and/or (2) medical and nonmedical records relevant to determination of medical issues; Letters to AME constituted "communications" under Labor Code § 4062.3(f), which need only be served on other party, rather than "information" under Labor Code § 4062.3(a), which requires that parties agree before "information" can be provided to medical evaluators. Maxham v. California Department of Corrections and Rehabilitation; State Compensation Insurance Fund, Defendants, 82 Cal. Comp. Cases 136; 2017 Cal. Wrk. Comp. LEXIS 6 (En Banc); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.06[1][d], [3], 22.11[18]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.04[3].]

California Insurance Guarantee Association—Medicare—Reimbursement—CMS held only entitled to that portion of medical treatment provided by CIGA pursuant to an accepted industrial injury, and not non-industrial treatment despite charges containing diagnosis codes covered and diagnosis codes not covered by workers' compensation insurance policies. California Insurance Guarantee Association v. Sylvia Mathews Burwell, Secretary Of Health And Human Services; United States Department Of Health & Human Services; And Center For Medicare & Medicaid Services (United States District Court For The Central District Of California) 227 F. Supp. 3d 1101; 2017 U.S. Dist. LEXIS 1681; 96 Fed. R. Serv. 3d (Callaghan) 793; 82 Cal. Comp. Cases 47; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 29.09[2][c], [e], [g]. Sullivan on Comp, Section 3.47, California Insurance Guarantee Association]

Lien Claimant—Medicare—Reimbursement—CMS held only entitled to that portion of medical treatment provided by CIGA pursuant to an accepted industrial injury, and not that portion of non-industrial treatment despite charges containing diagnosis codes covered and diagnosis codes not covered by workers' compensation insurance policies. California Insurance Guarantee Association v. Sylvia Mathews Burwell, Secretary Of Health And Human Services; United States Department Of Health & Human Services; And Center For Medicare & Medicaid Services (United States District Court For The Central District Of California) 227 F. Supp. 3d 1101; 2017 U.S. Dist. LEXIS 1681; 96 Fed. R. Serv. 3d (Callaghan) 793; 82 Cal. Comp. Cases 47; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 29.09[2][c], [e], [g]. Sullivan on Comp, Section 3.47, California Insurance Guarantee Association]

California Insurance Guarantee Association-Other Insurance-CIGA held not entitled to reimbursement where prior injury settled by C&R before CIGA injury, as defendant for prior injury was no longer liable to applicant for benefits and was not "other insurance" for purposes of relieving CIGA of liability for benefits following applicant's second injury. Riddle v. Las Flores Convalescent Hospital, CIGA by its servicing facility Intercare Insurance Services, for Ullico Casualty Co., in liquidation, 2017 Cal. Wrk. Comp. P.D. LEXIS 20 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 2.84[3][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, § 3.33[3]; Sullivan on Comp, Section 3.47, California Insurance Guarantee Association]

Injury AOE/COE-Off-Duty Social Activities-Intoxication-Injury as result of MVA held not compensable where applicant drinking occurred after his shift was completed, at restaurant/bar open to public, was not employer condoned drinking on job, applicant was not called back to work, owner not present, no special meeting, event or party, nor performing service for employer, and no reasonable belief per Labor Code § 3600(a)(9) and Ezzy v. W.C.A.B. (1983) 146 Cal. App. 3d 252, 194 Cal. Rptr. 90, 48 Cal. Comp. Cases 611. Carrillo v. LLG Corporation, dba Fresco II, Employers Compensation Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 658 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 4.20, 4.25; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, §§ 10.03[1], 10.05[6]. Sullivan on Comp, Section 5.22, Intoxication]; See also, Hansen v. Par Electrical Contractor, Inc. 2016 Cal.Wrk.Comp. P.D. LEXIS 661 holding evidence of acute alcohol intoxication held substantial and proximate cause of accident as and when it occurred and bar to recovery.

Medical Treatment—Utilization Review—Home Health Care Evaluations—UR appropriate for home health care evaluation as home health care determined to be form of "medical treatment" subject to UR under Labor Code § 4610. Note footnote suggest that "home health care evaluation" might also be med-legal expense. Rodriguez v. Simi Valley Unified School District, 2016 Cal. Wrk. Comp. P.D. LEXIS 671; 82 Cal. Comp. Cases 43 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 5.04[6], 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.05[3], 4.10. Sullivan on Comp, Section 7.2, Scope of Care – Cure or Relieve]

Medical Treatment-Utilization Review-Independent Medical Review- Request for authorization for specific treatment modality altered during UR process into different treatment request, matter remanded for determination as to whether, in light of significant error in UR of treatment requested, UR was untimely and whether WCJ had jurisdiction to determine medical dispute. Nungaray v. Remediation Constructors, Inc., State Compensation Insurance Fund, 2017 Cal. Wrk. Comp. P.D. LEXIS 16 (BPD)

[See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11. Sullivan on Comp, Section 7.41, Independent Medical Review—Appeal and Implementation of Determinations]

Temporary Disability-Temporary Partial Disability-Undocumented Workers- Undocumented farm laborer was entitled to temporarily partially disabled during period for which benefits were awarded despite undocumented work status; Entitlement to temporary disability benefits cannot be effected by immigration status, but undocumented applicant may not be provided with more extensive benefits than similarly situated worker who was working in United States legally as doing so would violate constitutional right to equal protection citing Del Taco v. W.C.A.B. (Gutierrez) (2000) 79 Cal. App. 4th 1437, 94 Cal. Rptr. 2d 825, 65 Cal. Comp. Cases 342. Romero v. Plantel Nurseries, Inc., AGG Cap Insurance Ltd, 2016 Cal. Wrk. Comp. P.D. LEXIS 672 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 3.31, 7.01[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 2, § 2.01[4], Ch. 6, § 6.10. Sullivan on Comp, Section 9.26, Temporary Disability for Terminating Employees]

Medical—Legal Procedure—Assignment and Selection of Panel Qualified Medical Evaluators—Specialty Designation—Orthopedic panel specialty was correct panel notwithstanding applicant's request for chiropractic panel; Parties' Labor Code § 4062.2, right to designate specialty is not absolute, and Medical Director has authority under 8 Cal. Code Reg. §§ 31and 31.1(b) to issue panel in different specialty if that specialty is more appropriate than specialty designated by requesting party. Garza v. O'Reilly Auto Parts, Corvel, 2017 Cal. Wrk. Comp. P.D. LEXIS 3; 82 Cal. Comp. Cases 424 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[2], [4], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[2], [4], Ch. 19, § 19.37. Sullivan on Comp, Section 14.29, Medical-Legal Process]

Medical-Legal Procedure-Qualified Medical Evaluators-New Injuries-Applicant entitled to second QME where claimed back injury involved two cases with separate and distinct injuries with different causes, citing Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418 (Appeals Board en banc opinion). Feige v. State of California Department of Corrections, 2017 Cal. Wrk. Comp. P.D. LEXIS 10 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.11[11], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[11], Ch. 19, § 19.37. Sullivabn on Comp, Section 14.52, Subsequent Evaluations and Additional QME]

Due Process- WCJ cannot compel parties to settle their dispute in particular way, nor can defendant's due process right to trial be made contingent on obtaining job analysis. Alvirde v. Barrett Business Services, 2017 Cal. Wrk. Comp. P.D. LEXIS 5 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 21.02[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 13, § 13.01[2]. Sullivan on Comp, 14.74, Resolution by C&R]

Workers' Compensation Judges-Disqualification-WCJ disqualified for bias pursuant to Labor Code § 5311, Code of Civil Procedure § 641 and 8 Cal. Code Reg. § 10452, where (1) without hearing testimony or receiving evidence on issues raised by parties granted defendant's petition for credit, and (2) used language suggesting bias against applicant including that applicant was vexatious litigant and that applicant's allegations were "nearly incomprehensible", both without supporting evidence and determined factually untrue and improperly dismissive of claims made. Fassett v. Bruce K. Hall Construction, 2017 Cal. Wrk. Comp. P.D. LEXIS 9 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][b][iii], 26.03[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 1, § 1.09[3], Ch. 16, § 16.08[2]. Sullivan on Comp, Section 15.54, Disqualification and Reassignment of Judge.]

Due Process- Neither the Labor Code nor the WCAB Rules permit parties to choose their own judges. (*See* Lab. Code, §§ 5310, 5311; Cal. Code Regs., tit. 8, §§ 10452 , 10453.) Flores v. Epic Management, The Hartford, 2017 Cal. Wrk. Comp. P.D. LEXIS 11 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 21.02[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 13, § 13.01[2]; Sullivan on Comp, Section 15.54, Disqualification and Reassignment of Judge.]

Third Party Actions-Employer Credit-Settlement of Civil Case- Civil settlement agreement not submitted

to WCAB for approval as required under Labor Code §§ 5001 and 5002, and based on applicant's credibly testified that he had no intention of settling his workers' compensation case, will not settle applicant's rights to workers' compensation benefits. Harris v. Trendwest Resorts, Inc./Cendant Corporation, 2017 Cal. Wrk. Comp. P.D. LEXIS 31(BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 11.42[5], 29.07[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 12, § 12.02[4], Ch. 18, § 18.13[4]; Sullivan on Comp, Section 2.18, Judicially Created Exceptions To Exclusive Remedy Rule.]

Employment Relationships-Volunteers-Job Applicants- Volunteer claiming injury due to state-mandated TB test held insufficient connection between completing state-mandated TB test and volunteer activity to support finding of employment relationship between applicant and defendant. Washington v. Pacific Hospice Anchor Medical Group, 2017 Cal. Wrk. Comp. P.D. LEXIS 77 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 3.62, 3.82[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 2, §§ 2.01[1], 2.03[1]. Sullivan on Comp, Section 4.52, Volunteers]

Cumulative Trauma Injuries—Employers' Liability—Indian Tribes—Pursuant to Labor Code § 5500.5, employee's cumulative trauma was limited to last year of injurious exposure, excluding Federal Indian Tribes as Labor Code § 5500.5 should not limit liability to tribal employers where the WCAB lacked jurisdiction over tribe, and evidence established that employee, while employed by non-tribal employer, sustained a compensable cumulative trauma injury AOE/COE. County Of Riverside v. WCAB (Sylves) (4th Appellate District) 10 Cal. App. 5th 119; 215 Cal. Rptr. 3d 693; 82 Cal. Comp. Cases 301; 2017 Cal. App. LEXIS 269; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 21.02[2], 31.13[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1][d]; Sullivan on Comp, Section 5.7, Cumulative Injury – Liability.]

Medical Provider Networks-Utilization Review- Treatment requests from all physicians, even those treating within MPN, must go through UR/independent medical review (IMR) process mandated by Labor Code § 4610 et seq., and that existing law requires RFAs for medical treatment be utilized by MPN physicians and are subject to all UR requirements. Bonilla v. San Diego Personnel and Employment dba Good People Employment Services, 2017 Cal. Wrk. Comp. P.D. LEXIS 56 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]; Sullivan on Comp, Section 7.34, Utilization Review – Requests for Authorization.]

Medical Treatment—Utilization Review—Earlier denial of treatment by UR physician based upon mistaken belief that requested treatment was solely for cosmetic purposes rather than required to alleviate pain associated with applicant's burn injury and restore functionality in his arm, held not barred by 12 months pursuant to Labor Code § 4610(g)(6) nor 8 Cal. Code Reg. § 9792.9(o)...defining phrase "a documented change in the facts material to the basis of the utilization review decision". De La Garza v. Roll Global/Del Rey Juice Plant dba POM Wonderful, 2017 Cal. Wrk. Comp. P.D. LEXIS 61; 82 Cal. Comp. Cases 549 (BPD). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11. Sullivan on Comp, Section 7.36, UR - Procedures]

Medical Treatment-Utilization Review-Independent Medical Review-Citing and affirming State Comp. Ins. Fund v. W.C.A.B. (Margaris) (2016) 248 Cal. App. 4th 349, 207 Cal. Rptr. 3d 875, 81 Cal. Comp. Cases 561, an employer who fails to undertake timely UR, medical treatment request is not subject to IMR and WCAB may exercise jurisdiction to decide whether requested treatment is medically necessary. Rios v. Bryan Jones dba The KB Group, 2017 Cal. Wrk. Comp. P.D. LEXIS 70 (BPD), [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]. Sullivan on Comp, Section 740, IMR]

Medical Provider Networks—Utilization Review—Treatment recommendations of medical provider network treating physician, where disputed by employer, may only be disputed through utilization review/independent medical review process; Commissioner Sweeney, concurring, wrote separately to emphasize that, even if employer raises dispute with medical provider network treating physician's

recommendation and submits issue to utilization review, injured worker may, at same time, exercise his or her right to initiate second opinion process provided in Labor Code § 4616.3 or change treating physicians within medical provider network. Parrent v. Workers' Compensation Appeals Board, Pacific Bell Telephone Co. SBC, 82 Cal. Comp. Cases 155; 2017 Cal. Wrk. Comp. LEXIS 3 (Writ Denied); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]. Sullivan on Comp, Section 7.55, MPN – Dispute Resolution]

Credit—Employer Benefit Plan—When employee and employer both make contributions to disability pension plan, the employer's right to credit as against TD is proportional, citing City of LA v. IAC (Fraide) (1965) 30 Cal.Comp.Cases 243 and Labor Code Section 3751(a). Padron v. Frito Lay, PSI, adjusted by Sedgwick CMS, 2017 Cal. Wrk. Comp. P.D. LEXIS 69; 82 Cal. Comp. Cases 639 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 7.04[9][b]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, § 6.19[2]. Sullivan on Comp, Section 9.32, Credit for Payment if Benefits].

Permanent Disability-Rating-Sleep Dysfunction- Obesity is considered physical injury even if it does not arise out of physical trauma, and any increase in permanent disability for sleep dysfunction caused by obesity is barred by Labor Code § 4660.1(c)(1). Castillo v. City of Los Angeles, PSI, 2017 Cal. Wrk. Comp. P.D. LEXIS 58 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4], 32.02[2], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, § 7.05[3][b]; The Lawyer's Guide to the AMA Guides and California Workers' Compensation, Chs. 2, 6. Sullivan on Comp, Section 10.16; Use of 2013 PD Schedule]

Permanent Disability-Rating-AMA Guides-VR expert's opinion held substantial evidence despite failure to conduct labor market survey and conducting interview of applicant via Skype, as 8 Cal. Code Reg. § 10606.5 does not require labor market survey nor prohibition against use of video technology such as Skype. Lehman v. Walgreens, Zurich American Insurance Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 66 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4][a], 32.02[2], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA Guides and California Workers' Compensation, Chs. 3, 4, 5, 8, 9, 10.]

Permanent Disability—Apportionment—Substantial Medical Evidence—Genetics—Questionable analysis holding that apportionment may properly be based on genetics/hereditability, i.e., apportionment based on pathology and asymptomatic prior conditions for which the worker has an inherited predisposition," and that "no relevant distinction between allowing apportionment based on a preexisting congenital/pathological condition and allowing apportionment based on a preexisting degenerative condition caused by heredity or genetics. City Of Jackson v. WCAB (Rice), (3rd Appellate District) 11 Cal. App. 5th 109; 216 Cal. Rptr. 3d 911; 82 Cal. Comp. Cases 437; 2017 Cal. App. LEXIS 383; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[1], [2][a], 8.06[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.40[2], [3], 7.41[3]. Sullivan on Comp, Section 10.34, Apportionment – Pre-Existing Disease or Condition]

Medical Treatment-Utilization Review-Home Health Care-Home Health Care stopped as record contained scant evidence to determine whether Patterson v. The Oaks Farm (2014) 79 Cal. Comp. Cases 910 (Appeals Board significant panel decision), conditions applied and could not say that defendant's decision to rely on utilization review determination denying certification for continued home healthcare was inappropriate. Garas v. RXI Plastics, Inc., State Compensation Insurance Fund, 2017 Cal. Wrk. Comp. P.D. LEXIS 90 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 5.04[6], 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.05[3], 4.10. Sullivan on Comp, Section 7.2, Scope of Care]

Medical Treatment-Utilization Review- RFA held proper despite incorrect claim number where employee successfully identified triggering UR timeline under 8 Cal. Code Reg. § 9792.6.1, and defendant otherwise received information reasonably necessary to make UR determination under Labor Code § 4610(g)(1). Weimer v. Hillyard, Inc., California Insurance Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 104 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11. Sullivan on Comp, Section 7.34, Utilization Review]

Temporary Disability—Permanent and Stationary Status—Utilization Review—UR denial of surgery coupled with AME opinion that absent applicant had reached permanent and stationary status, supported finding of P&S; but see contra, San Francisco Police Dept. v. W.C.A.B. (Casey) (2014) 79 Cal. Comp. Cases 970 (writ denied). Keltner v. California Guest Services, Inc., Chubb Group of Insurance Companies, 2017 Cal. Wrk. Comp. P.D. LEXIS 94; 82 Cal. Comp. Cases 629 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 7.02[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, § 6.01[1].]

Psychiatric Injury-Violent Acts-Increased Permanent Disability-Held compensable psychiatric injury under "violent act" exception in Labor Code § 4660.1(c) because "violent acts" include acts that are characterized by either strong physical force, extreme or intense force, or act that is vehemently or passionately threatening as was applicant's truck accident in this case, which left applicant with broken neck and pinned under his overturned tractor trailer until he was rescued by "jaws of life, citing Larsen v. Securitas Security Services, 2016 Cal. Wrk. Comp. P.D. LEXIS 237 (Appeals Board noteworthy panel decision). Madson v. Michael J. Cavaletto Ranches, Zenith Insurance Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 95 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§4.02[3][a], [b], [f], 4.69[1], [3][a], 8.02[4][c][ii], [5], 32.02[2][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.05[3][b][i][ii], 7.06[6], Ch. 10, § 10.06[3][a], [b][i]; Sullivan on Comp, Section 10.16, Use of 2013 PD Schedule.]

Cumulative Injury-Single Cumulative Trauma Period-Injurious Exposure-Substantial evidence supported single cumulative injury extending throughout applicant's entire professional football career, where periods of employment were linked with applicant receiving medical treatment for injured body parts, including surgeries, medications and electrical stimulation in accordance with Western Growers Ins. Co. v. W.C.A.B. (Austin) (1993) 16 Cal. App. 4th 227, 20 Cal. Rptr. 2d 26, 58 Cal. Comp. Cases 323. Newberry v. San Francisco Forty Niners, Atlanta Falcons, Oakland Raiders, San Diego Chargers, ESIS, Tristar, Zenith Insurance, Berkley Specialty, Travelers Insurance, 2017 Cal. Wrk. Comp. P.D. LEXIS 143 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.01[2][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1]. Sullivan on Comp, Section 5.6, Defining Multiple Injury Dates]

Discovery-Home Health Care Assessment-Right to Privacy-Defense attorney not allowed to be present in applicant's home during home health care assessment as contrary to purpose of Labor Code § 4052, which is meant to provided protection only to the applicant, and allowing would be tactic to intimidation, disruptive to assessment, would invade applicant privacy and the sanctity of applicant's home, and is without equitable reason. Zamudio v. Starco Enterprises, California Insurance Guarantee Association, 2017 Cal. Wrk. Comp. P.D. LEXIS 151 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.07[2][a], 25.40, 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1], Ch. 19, § 19.37.]

Medical Treatment-Utilization Review-Time Deadlines-UR held untimely where notice given by fax of only first 20 pages of 25 page UR decision (8 Cal. Code Reg. § 9792.9.1(e)(5)), and missing pages contained name/qualifications of UR reviewer, list of medical records reviewed and notification of UR appeals process. Ingle v. Department of Motor Vehicles, State Compensation Insurance Fund, Defendants, 2017 Cal. Wrk. Comp. P.D. LEXIS 137 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][c], 22.05[6][b][iii]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10[4]. Sullivan on Comp, Section 7.36, Utilization Review – Procedures].

Temporary Disability-Temporary Partial Disability-Undocumented Workers-Applicant not entitled to temporary disability benefits pursuant to Insurance Code § 1171.5, when applicant was undocumented worker at time of his injury and resigned from his employment because he was worried about potential jail time; Because employer knew applicant was not legally working in United States at time he claimed temporary disability, employer was not required to offer applicant modified or alternative work. Venancio v. White Labs, Inc., Cypress Insurance Company, administered by Berkshire Hathaway, 2017 Cal. Wrk. Comp. P.D. LEXIS 181(BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 3.31, 7.01[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 2, § 2.01[4], Ch. 6, § 6.10. Sullivan on Comp, Section 9.26, Temporary Disability for Terminated Employees].

Discovery-Medical Records-Defendant not allowed to discover applicant medical records regarding HIV/AIDS where claim alleged that decedent's death was caused by industrial exposure to asbestos; Filing workers' compensation claim does not cause injured worker to sacrifice all privacy rights with respect to medical information; Commissioner Razo, dissenting, opined that medical records regarding decedent's HIV/AIDS status were discoverable, and he would return matter to WCJ to determine how best to protect decedent's privacy rights while permitting defendant to review relevant medical records. Morgan v. National Steel and Shipbuilding Company, PSI, Campbell Industries, Zenith Insurance Company, State Compensation Insurance Fund, California Insurance Guarantee Association, 2017 Cal. Wrk. Comp. P.D. LEXIS 141(BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 25.40, 25.43, 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45, Ch. 19, § 19.37. Sullivan on Comp, Section 14.17, Privacy of Employee with HIV/AIDS].

Superior Court Jurisdiction—Workers' Compensation System—Permanent Disability Benefits—Discrimination Based on Gender—Superior Court lacked subject matter jurisdiction over allegations that California workers' compensation system unlawfully discriminates on basis of sex/gender in calculation of permanent disability benefits citing Labor Code § 5955. Page, Hansen, Gonzalez, v. Acting Administrative Director of the Division of Workers' Compensation, (Superior Court Of California, County Of Los Angeles) 82 Cal. Comp. Cases 352; 2017 Cal. App. LEXIS 299; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 34.02; Rassp & Herlick, California Workers' Compensation Law, Ch. 13, §§ 13.08[1], 13.09[1].]

Third-Party Actions—Employer's Claim for Credit—Vaccine Injury Compensation Program—Defendant not entitled to credit pursuant to Labor Code §§ 3852–3862 against its workers' compensation liability for applicant's recovery from National Vaccine Injury Compensation Program (NVICP) (42 U.S.C.S. § 300aa-10 et seq.) for injury caused by adverse reaction to company-sponsored flu vaccine. Sywassink v. Pacific Gas and Electric Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 205; 82 Cal. Comp. Cases 803 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 11.42[5]; Rassp & Herlick, California Workers' Compensation Law, Ch. 12, § 12.10[2].]

Cumulative Injury-Single Cumulative Trauma Period-Injurious Exposure-Applicant suffered single cumulative trauma to his heart, neck, low back, right knee, and left foot while working as correctional officer noting that LC despite that there were two different dates of injury under Labor Code § 5412 for applicant's heart and orthopedic injuries, there was one period of injurious exposure for purposes of determining liability under Labor Code § 5500.5, and that date of injury under Labor Code § 5412 has relevance to statute of limitations and allocation of liability for cumulative injury under Labor Code § 5500.5, but does not determine whether employee sustained one or two cumulative injuries. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.01[2][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1].]

Cumulative Injury-Single Cumulative Trauma Period-Injurious Exposure- Single cumulative trauma injury to heart, neck, low back, right knee, and left foot while working as correctional despite there two different dates of injury under Labor Code § 5412 for applicant's heart and orthopedic injuries, but one period of injurious exposure for purposes of determining liability under Labor Code § 5500.5. Bass v. State of California, Department of Corrections & Rehabilitation, 2017 Cal. Wrk. Comp. P.D. LEXIS 213 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.01[2][a]; Rassp & Herlick,

California Workers' Compensation Law, Ch. 10, § 10.06[1]. Sullivan on Comp, Section 5.6, Defining Multiple Injury Dates]

Temporary Disability-Temporary Partial Disability- Applicant not entitled to temporary disability indemnity on wage-loss basis after she returned to work for time she spent seeking medical treatment during working hours, as applicant's entitlement to temporary disability ended when she returned to work in full capacity, citing Ward v. Workers' Comp. Appeals Bd.(2004) 69 Cal.Comp.Cases 1179,1182 [writ denied]. Henry v. Superior Court of California, San Joaquin County, 2017 Cal. Wrk. Comp. P.D. LEXIS 217 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 7.01[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 6, §§ 6.01, 6.10. Sullivan on Comp, Section 7.5, Reasonable Expenses Incident to Treatment.]

Average Weekly Wage-Calculation-Average weekly wage pursuant to Labor Code § 4453(c)(4) calculated applying a 40-hour work week held invalid where applicant's work was irregular and he never worked 40-hour week, as earning capacity is benchmark for calculating average weekly earnings at time of injury; Applicant's earning capacity is best calculated by taking average weekly wage as reflected in several years before his injury. Loyd v. Dolan Concrete Construction, Old Republic Contractors Insurance Group, 2017 Cal. Wrk. Comp. P.D. LEXIS 198 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 6.02[1]-[3], [5]; Rassp & Herlick, California Workers' Compensation Law, Ch. 5, §§ 5.01, 5.03, 5.04, 5.09. Sullivan on Comp, Section 8.10, Average Weekly Earnings].

Psychiatric Injury—Violent Acts—Increased Permanent Disability—Applicant's mechanism of injury which involved falling 20 feet, loss of helmet, and swinging from tether, hitting head against tree truck several times and losing consciousness constitutes a "violent act" as defined in § 3208.3(b) defined as "an act that is characterized by either strong physical force, extreme or intense force, or an act that is vehemently or passionately threatening." Torres v. Greenbrae Management, State Compensation Insurance Fund, 2017 Cal. Wrk. Comp. P.D. LEXIS 230 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 4.02[3][a], [b], [f], 4.69[1], [3][a], 8.02[4][c][ii], [5], 32.02[2][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.05[3][b][i][ii], 7.06[6], Ch. 10, § 10.06[3][a], [b][i].]

Discovery-Vocational Evaluations-Recording-Stenographically recording vocational evaluation is not allowed by statute, or by regulation (including CCP 2032.510 which does not apply), although WCJ has discretion to decide whether or not to allow recording of vocational examinations in certain circumstances, after hearing and upon evidence establishing good cause to allow recording of vocational evaluation. Cann v. Desert View Auto Auction, Insurance Company of the State of Pennsylvania, 2017 Cal. Wrk. Comp. P.D. LEXIS 214 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.07, 25.40, 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1], Ch. 19, § 19.37.]

Injury AOE/COE—Compensable Consequence Injuries—Causation of injury established through acceleration or aggravation of preexisting industrial injury is compensable as separate injury AOE/COE if aggravation is reasonably attributable to employee's subsequent employment, despite that the prior industrial injury was contributing factor. Subsequent employer defendant may not avoid liability as issue is apportionment of liability as between co-defendants, rather than causation of injury citing Smith v. Workmen's Comp. App. Bd. (1969) 71 Cal.2nd 588, 34 Cal. Comp. Cases 424. Ponce v. Barrett Business Services, Inc., PSI, State Compensation Insurance Fund, 2017 Cal. Wrk. Comp. P.D. LEXIS 175; 82 Cal. Comp. Cases 786 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.05[2][a]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.04.]

Injury AOE/COE—Burden of Proof—Adverse Inferences—WCJ required to address Applicant entitled to adverse inference that his prostate cancer was industrially caused due to defendant's failure to produce Hazard Awareness Recognition Program (HARP) forms, which applicant alleged defendant was required to do pursuant to state and federal law, and WCAB, noting that 29 C.F.R. § 1910.1020(d) requires that employee medical records and exposure records be maintained for at least thirty years; WCJ has wide discretion in determining whether and to what extent adverse inference should be made. Skaff, Applicant v.

City of Stockton, 2017 Cal. Wrk. Comp. P.D. LEXIS 148; 82 Cal. Comp. Cases 794 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 4.02[3][b], 4.05[2][a], [d], [3][a], 27.01[1][c]; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.01[4].]

WCAB Jurisdiction-Professional Athletes-Subject Matter Jurisdiction-Where evidence established that applicant played for California team during portion of cumulative injury period (1994 and 1995), and that applicant's was hired in California by Fresno Falcons in 1994, sufficient connection with California to support WCAB subject matter jurisdiction pursuant to Labor Code §§ 3600.5(a) and 5305, notwithstanding number of games in which applicant participated while in state. Huscroft v. Calgary Flames, Fresno Falcons, Stockton Thunder, Tampa Bay Lightning, Vancouver Canucks, Phoenix Coyotes, Washington Capitals, Federal Insurance Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 220 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 3.22[2], [3], 21.02, 21.06, 21.07[5]; Rassp & Herlick, California Workers' Compensation Law, Ch. 13, § 13.01[2].]

Liens-Medical-Reasonableness of Charges-Burden of Proof-Long-term care hospitals are exempt from Official Medical Fee Schedule (OMFS) and must be paid on reasonable cost basis pursuant to 8 Cal. Code Reg. § 9789.22(k)(5), and consistent with Kunz v. Patterson Floor Coverings, Inc. (2002) 67 Cal. Comp. Cases 1588 (Appeals Board en banc opinion). Reyes v. Leegin Creative Leather Products, Travelers Property Casualty Company of America, 2017 Cal. Wrk. Comp. P.D. LEXIS 45 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 30.04[3][a], [9]-[12]; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.70[1][b].]

Medical-Legal Procedure-Medical Examiner Reporting Timeframes-Replacement Panels-Untimely supplemental report not proper basis for replacement panel despite the requirement of 8 Cal. Code Reg. § 38(i) that supplemental reports issue within 60 days, because Labor Code § 4062.5 does not mandate replacement qualified medical evaluator panel for untimely supplemental reports. Dorantes v. Dirito Brothers and Insurance Co. of the West, 2017 Cal. Wrk. Comp. P.D. LEXIS 237 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.11[4], [6], 22.13; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[6], [14].]

Medical-Legal Procedure-Qualified Medical Evaluator Panel Requests-Where claim disputed AOE/COE, objection to treating physician's report not necessary prior to obtaining panel qualified medical evaluator under Labor Code §§ 4060 and 4062.2 on AOE/COE basis. Espinoza v. GFC Holdings, Inc., Redwood Fire and Casualty Insurance Company c/o Berkshire Hathaway Homestate Companies, 2017 Cal. Wrk. Comp. P.D. LEXIS 239 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.11[1], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[1], Ch. 19, § 19.37.].

Medical-Legal Procedure-Additional Examinations-Consultation re-examination regarding ongoing medical treatment with AME pursuant to Labor Code § 4050 held improper, as original purpose of Labor Code § 4050 was subsumed by more specific statutes, including Labor Code §§ 4060, 4061, 4062, and 4610, citing Nunez v. WCAB 136 Cal.App. 4th 584, 71 Cal.Comp. Cases 16, and Batten v. WCAB (2015) 241 Cal.App.4th 1009. Catlin v. J.C. Penney, Inc., American Home Assurance Co., 2017 Cal. Wrk. Comp. P.D. LEXIS 106 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1], 22.07[2][a], 22.11[11], 24.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03, Ch. 16, § 16.54[11], Ch. 19, § 19.37.]

Medical Treatment-Utilization Review-Disputed Injuries-Once defendant decides to proceed with UR, and having failed to act timely within five-day timeframe in 8 Cal. Code Reg. § 9792.9.1(b)(1) to defer liability for recommended treatment, defendant cannot later decide to delay medical treatment approved by UR on basis that it is disputing industrial injury. Mata v. Supermercado Mi Tierra, LLC, California Insurance Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 166 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11.]

Medical Treatment-Utilization and Independent Medical Review-Binding Agreement to Utilize Agreed Medical Examiner-Binding agreement to use AME to resolve medical disputes is consistent with underlying purpose of UR/IMR statutory changes discussed in Stevens v. WCAB (2015) 241 Cal. App. 4th 1074, 80 Cal.Comp. Cases 1262, as it obviated need to litigate future treatment disputes through the more protracted IMR review and appeal processes. Payne v. Federal Express, PSI, and Administered by Broadspire, 2017 Cal. Wrk. Comp. P.D. LEXIS 243 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11.]

Permanent Disability-Rating-Combined Values Chart-Application of CVC appropriate where opinion of AME regarding the lack of synergistic effect among applicant's various injuries was found more persuasive than other medical opinions in record indicating that disabilities to different body parts/systems should not be combined using CVC; Application of CVC produced accurate reflection of disability. Commissioner Sweeney, dissenting, Application of CVC improper where overlap of spine, psychiatric and internal impairments not established. Foxworthy v. State of California, Department of Parks and Recreation, Legally Uninsured, 2017 Cal. Wrk. Comp. P.D. LEXIS 86 (BPD; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4][a], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA Guidesand California Workers' Compensation, Ch. 6.]

Permanent Disability-Rating-Permanent Total Disability-100 percent permanent disability "in accordance with the fact" under Labor Code § 4662(b) upheld where based upon AME due to combination of failed back surgery/strong pain medications constituted substantial medical evidence with need for VR expert; Orthopedic AME may properly assess that from medical standpoint applicant was unable to compete in labor market. Truesdell v. Von's Grocery Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 102 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4], 32.02[2], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA Guides and California Workers' Compensation, Chs. 3, 4, 5, 8.].

Permanent Disability-Rating-Diminished Future Earning Capacity-Opinion of VR expert does not constitute substantial evidence where VR expert failed to address whether permanent total disability was solely caused by industrial injury, or in part by non-industrial causation; Labor Code § 4663 and Benson v. W.C.A.B. (2009) 170 Cal. App. 4th 1535, 89 Cal. Rptr. 3d 166, 74 Cal. Comp. Cases 113, which requires that applicant's permanent total disability be apportioned among his various industrial injuries is applicable to VR opinions where multiple and successive injuries exist; The Combined Values Chart is reserved for combining disability caused by a single injury. Singh v. State of California, Legally Uninsured, 2017 Cal. Wrk. Comp. P.D. LEXIS 204 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4][a], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA Guides and California Workers' Compensation, Ch. 8.]

Permanent Disability-Offers of Regular, Modified or Alternative Employment-Increased Permanent Disability Award-In the absence of voluntary payment giving rise to tacit admission that Labor Code § 4658(d)(2) applied, or undisputed evidence to support application, it is the applicant, who has the burden of proof on the issue of establishing that 15 percent increase applies to include establishing whether employer had 50 or more employees, and whether defendant ever sent applicant conforming offer of regular, modified or alternative work, distinguish and explaining Bontempo v. W.C.A.B. (2009) 173 Cal. App. 4th 689, 93 Cal. Rptr. 3d 229, 74 Cal. Comp. Cases 419. Gamez v. Newport Mesa Unified School District, PSI, Administered By Keenan Associates, 2017 Cal. Wrk. Comp. P.D. LEXIS 89 (BPD);
[See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 7.02[4][d][iii], 32.04[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, § 7.51[2].]

Workers' Compensation § 83—Award—Apportionment—Medical Treatment—Changes in Law.—Employer held responsibility for the consequences of medical treatment and resulting PD without apportionment. Hikida v. WCAB, Costco (2nd Appellate District) 12 Cal. App. 5th 1249; 219 Cal. Rptr. 3d 654; 82 Cal. Comp. Cases 679; 2017 Cal. App. LEXIS 572; See also, County of Sac. v. WCAB (Chimeri)

75 CCC 159; Nilsen v. Vista Ford 2012 Cal.Wrk.Comp.P.D. LEXIS 528; Moran v. Dept. of youth Authority 2011 Cal.Wrk.Cop. P.D. Lexis 43; Steinkamp v. City of Concord 2006 Cal.Wrk.Comp. P.D. LEXIS 24; [Herlick, California Workers' Compensation Law (6th ed. 2016) ch. 4, § 4.01. Sullivan on Comp, Section 10.34, Apportionment]

Discovery-Vocational Evaluations-Recording-Although the WCJ has discretion to decide whether or not to order recording of vocational examinations, such an order requires that evidence be provided establishing good cause to allow recording of vocational evaluation. Cann v. Desert View Auto Auction, Insurance Company of the State of Pennsylvania, 2017 Cal. Wrk. Comp. P.D. LEXIS 214 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.07, 25.40, 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1], Ch. 19, § 19.37; Sullivan on Comp, Section 10.19, Rebutting Schedule under Ogilvie]

Discovery-Subpoenas- WCJ held that applicant's twin brother could not be compelled to appear at mandatory settlement conference and produce certain documents, including social security card and/or other documents to demonstrate legal residence, despite applicant's claim that surveillance video obtained by defendant depicted applicant's twin brother, not applicant, as applicant's twin brother was not party to case. Defendant had the right to subpoena twin for deposition and to testify at trial. Nedjar v. Parsec, Gallagher Bassett Corona, 2017 Cal. Wrk. Comp. P.D. LEXIS 224 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 25.40, 25.43; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1]. Sullivan on Comp, Section 14.16, Privacy]

Medical-Legal Procedure-Additional Evaluations-Applicant entitled to QME/AME re-examination on petition to reopen pursuant Labor Code § 4062.3(k), as the report after re-examination is admissible on existence, prior to end of five-year period, of new and further disability. Luisa Lopez, Applicant v. County of San Joaquin, PSI, administered by Tristar Risk Management2017 Cal. Wrk. Comp. P.D. LEXIS 197 [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.06[1][e], 32.06[1][f]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[4][f]. Sullivan on Comp, Section 14.52, Subsequent Evaluation and Additional Qualified Medical Evaluator Panels in Different Specialties]

Liens-Medical-Legal-Copy Services-Although attorney has broad discretion in deciding how to conduct discovery, attorney's broad discretion does not automatically allow for issuance of redundant subpoenas requesting documents that were ordered, obtained, and available from by prior counsel. Maya v. All Commercial Industries, State Compensation Insurance Fund, 2017 Cal. Wrk. Comp. P.D. LEXIS 223 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 30.05; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.72[1]. Sullivan on Comp, 14.64, Defining Medical-Legal Expenses]

Fair Employment and Housing Act - Nonemployee Sexual Harassment - The workers' compensation exclusive remedy doctrine is inapplicable to claims under the FEHA, and such claims against an employer are not subject to demurrer where the employee alleges facts that (1) employee was raped on employer property while working by drunk nonemployee; and (2) employer knew or should have known alleged rapist was on the property prior to the rape; and (3) employer knew or should have known that the alleged rapist presented risk of potential harm citing B & E Convalescent Center v. State Compensation Ins. Fund (1992) 8 Cal.App.4th 78, 89-92 [9 Cal.Rptr. 2d 894]; Meninga v. Raley's, Inc. (1989) 216 Cal.App.3d 79, 91 [264 Cal. Rptr. 319]; Jones v. Los Angeles Community College Dist. (1988) 198 Cal.App.3d 794, 808–809 [244 Cal. Rptr. 37]; see also Light v. Department of Parks & Recreation (2017) 14 Cal.App.5th 75, 97–98 [221 Cal. Rptr. 3d 668]. M.F. v. Pacific Pearl Hotel Management LLC, (2017) 16 Cal. App. 5th 693, 224 Cal. Rptr. 3d 542, 82 Cal. Comp. Cases 1304, 2017 Cal. App. LEXIS 933. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 10.70[3][b]; Sullivan on Comp, Section 2.20, Exceptions to Exclusive Remedy Rule for Violation of Public Policy.]

Liens - Insurer's Lien - Temporary Disability Payments –Workers' Compensation lien against third party recovery is properly reduced by amount of reasonable attorney fees and costs. Employer/Workers' Comp Carrier is entitled to recover the amount of TD paid despite the employee made no attempt to recover those lost wages from the third party. (§ 3856, subd. (b)). Duncan v. Walmart Stores, (Fourth Appellate District)

18 Cal.App.5th 460, 2017 Cal.App.LEXIS 1111. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 11.22[6], 11.42[2][a], [b]; Rassp & Herlick, California Workers' Compensation Law, Ch. 12, §§ 12.06[1], 12.08[4], 12.10; Sullivan on Comp, Section 2.39, Subrogation – Civil Suits]

Uninsured Employers Benefits Trust Fund-Liability for Reimbursement-UEFTF not legally obligated under Labor Code § 3715 to reimburse Workers' Compensation Carrier for benefits mistakenly provided to applicant on behalf of illegally uninsured employer because Labor Code § 3715 only contemplates payment of benefits to employees and does not contain any provision that could be construed as allowing payment of UEBTF funds to insurance companies as reimbursement. Prieto v. O.C. Contracting, Inc., American International Group, Inc., UEBTF, 2017 Cal. Wrk. Comp. P.D. LEXIS 498 (Split Panel Decision); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 22.13; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, § 3.19. Sullivan on Comp, Section 3.40, UEBTF]

Injury AOE/COE—Home as Workplace—Injury upheld as AOE/COE where applicant was in wheelchair due to nonindustrial disability and employer accommodated applicant's disability by allowing her to work from home for 10 months prior to incident, and thereby created applicant's home into worksite/workplace. Santa Clara Valley Transportation Authority v. Workers' Compensation Appeals Board (Tidwell) 82 Cal. Comp. Cases 1514, 2017 Cal. Wrk. Comp. LEXIS 129 (WD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.139; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.05[2][a]. Sullivan on Comp, Section 5.50, Home as Second Job Site]

Injury AOE/COE-Emergencies-Injury found where employee chased car thief as applicant's actions were normal human response and did not materially deviate from his employment, noting that employer did not discipline applicant for his actions indicating that applicant's employment was extended to include time and place of his injury. Miranda v. Southwest Airlines, Ace American Insurance Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 497 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 4.137; Rassp WCAB affirmed WCJ& Herlick, California Workers' Compensation Law, Ch. 10, § 10.05; Sullivan on Comp, Section 5.59, Personal Comfort Doctrine]

Liens-Medical-Independent Bill Review-Dispute regarding payment for treatment provided by lien claimant was subject to Independent Bill Review (IBR) and was not within jurisdiction of WCAB, when defendant objected to lien claimant's bills based on incorrect coding that did not comply with National Correct Coding Initiative (NCCI); that if "the only dispute is the amount of payment and the provider has received a second review that did not resolve the dispute," provider must request IBR within 30 days or bill will be deemed satisfied citing Labor Code § 4603.6(a). Senguiz v. City of Fremont, York Insurance, 2017 Cal. Wrk. Comp. P.D. LEXIS 522 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][e], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.24, Ch. 17, § 17.70[6]. Sullivan on Comp, Section 7.69, Independent Bill Review.]

Medical Liens - Stays of Liens - Due Process-Plaintiffs/lien claimant's whose liens had been automatically stayed, pursuant to Labor Code § 4615 was a violation of procedural due process as required under the Sixth Amendment of the U.S. Constitution. Vanguard Med. Mgmt. Billing v. Baker, 82 Cal.Comp.Cases 1368, 2017 U.S. Dist. LEXIS 182342; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.12[2A][e], 30.22[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 17, § 17.111[5], [9]; Sullivan on Comp, Section 7.77, Medical Expense.]

Credit-Overpayment of Temporary Disability- Defendant entitled to credit against permanent disability for overpaid temporary disability indemnity advances, but only at lower permanent disability rate, where report not served by evaluating physician for over five months after evaluation, no evidence in record that defendant took any steps to accelerate issuance of report, or that applicant acted in bad faith in accepting temporary disability indemnity benefits during overpaid period. Rogers v. American Medical Response, Ace American Insurance Company, 2017 Cal. Wrk. Comp. P.D. LEXIS 521(BPD); See also, accord, and holding Credit for TD overpayment within discretion of WCAB, Herrera v. WCAB (1969) 71 Cal.2d 254, 258, 34 Cal.Comp.Cases 382; and Cordes v. General Dynamics-Astronautics (1966) 31 Cal.Comp.Cases 429 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 7.04[9][a]; Rassp &

Herlick, California Workers' Compensation Law, Ch. 6, § 6.19[1]; Sullivan on Comp, Section 9.30, Credit for Overpayment of TD.]

Penalties-Delay in Payment of Settlement-No abuse of discretion citing and discussing factors outlined in Ramirez v. Drive Financial Services (2008) 73 Cal. Comp. Cases 1324 (Appeals Board en banc opinion), where a 5% 5814 penalty awarded, where defendant initially sent payment to applicant on time but applicant did not receive check, and defendant promptly corrected issue by issuing payment again within five days of learning that applicant had not receive payment. Hernandez v. 4 Diamond Construction, Benchmark Insurance, 2017 Cal. Wrk. Comp. P.D. LEXIS 515 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 10.40[1], [3], 27.12[2][c]; Rassp & Herlick, California Workers' Compensation Law, Ch. 11, § 11.11[1]-[3]; Sullivan on Comp, Section 13.12, LC 5814 – Rules of Payment.]

Penalties-Delay in Payment of Supplemental Job Displacement Voucher-Return-to-Work Supplemental Payments-Applicant was not entitled to Labor Code § 5814 penalty for delay in providing Labor Code § 4658.7 supplemental job displacement voucher resulting in applicant's delayed application for Labor Code § 139.48 return-to-work supplemental payment, as Labor Code § 139.48 supplemental payments held not employer's liability but are made from fund administered by Administrative Director and, therefore, are not compensation subject to penalty as defined by Labor Code § 3207 or within meaning of Labor Code § 5814(a). McFarland v. Redlands Unified School District, 2017 Cal. Wrk. Comp. P.D. LEXIS 495 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 10.40[1], [3], 27.12[2][c]; Rassp & Herlick, California Workers' Compensation Law, Ch. 11, § 11.11[1]-[3]; Sullivan on Comp, Section 13.25, Unreasonable Delay – Failure to Pay Supplemental Job Displacement Benefits.]

Medical-Legal Procedure-Qualified Medical Evaluators- Labor Code § 4062.2(f) only precludes withdrawal from agreed medical examiner *after* agreed medical examiner has conducted evaluation, but does not preclude unilateral withdrawal by party before submitting to evaluation. Yarbrough v. Southern Glazer's Wine and Spirits, 2017 Cal. Wrk. Comp. P.D. LEXIS 508 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[11], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[1], [2], Ch. 16, § 16.54[11], Ch. 19, § 19.37. Sullivan on Comp, Section 14.29, Medical-Legal Process – Represented Employee]

Medical Treatment—Utilization Review and Independent Medical Review—Binding Agreement to Utilize Agreed Medical Evaluator—2003 agreement within C&R to utilize AME on issues of future medical treatment was enforceable despite subsequent statutory changes implementing utilization review/independent medical review citing *Bertrand v. County of Orange*, 2014 Cal. Wrk. Comp. P.D. LEXIS 342 (Appeals Board noteworthy panel decision). Federal Express Corporation v. WCAB (Paynes) 82 Cal. Comp. Cases 1014, 2017 Cal.Wrk.Comp. LEXIS 91 (WD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11.]

Medical-Legal Procedure-Additional Examinations-Applicant may not be compelled to attend 4050 consultation re-examination with AME post C&R with open med, as the original purpose of Labor Code § 4050 was subsumed by more specific statutes, including Labor Code §§ 4060, 4061, 4062, and 4610, and Labor Code § 4050 cannot circumvent process set forth in these provisions. Catin v. J.C. Penney, Inc., American Home Assurance, 2017 Cal. Wrk. Comp. P.D. LEXIS 106 (BPD); See also, Batten v. Workers' Comp. Appeals Bd. (2015) 241 Cal.App.4th 1009, 1015 [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1], 22.07[2][a], 22.11[11], 24.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03, Ch. 16, § 16.54[11], Ch. 19, § 19.37.]

Medical-Legal Procedure-Medical Examiner Reporting Timeframes-Replacement Panels-Although 8 Cal. Code Reg. §38(i) creates guidelines for the timeline for supplemental QME report, the 60 day requirement when read with Labor Code §4062.5 does not mandate replacement QME Panel absent good cause such as that the delay would result in prejudice to the parties, and the issue of whether the QME report was substantial evidence was not grounds for replacement under 8 Cal. Code Reg. §31.5. Dorantes v, Dirito

Brouthers and Insurance Co. of the West, 2017 Cal. Wrk. Comp. P.D. LEXIS 237 (BPD); See also, Garcia v. Child Development, Inc. 2017 Cal.Wrk.Comp.P.D. Lexis 112, Alvarado v. CR&R Inc, 2016 Cal.Wrk.Comp.P.D. LEXIS 112, Corrando v. Aquafine Corp. 2016 Cal.Wrk.Comp.P.D. LEXIS 318 [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.11[4], [6], 22.13; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[6], [14].]

Attorneys-Withdrawal of Attorney- "Good cause" standard does not apply to requests to withdraw from representation, and that attorney may withdraw from case as long as withdrawal does not cause prejudice to client's case, even absent good cause, and withdrawal not at a critical stage with proper notice to applicant causes no prejudice to client's case. Thompkins v. Citizens Telecom, Continental Insurance Company, 2017 Cal.Wrk.Comp.P.D. LEXIS 300; See also, Ramirez v. Sturdevant (1994) 21 Cal.App.4th 904; Code Civ.Proc., § 284. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 20.01[3], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.04[6], Ch. 19, § 19.37.]

Cumulative Injury—Single Cumulative Trauma Period—Injurious Exposure—even though there were two different dates of injury under Labor Code § 5412 for applicant's heart and orthopedic injuries, there was one period of injurious exposure for purposes of determining liability under Labor Code § 5500.5, and that date of injury under Labor Code 5412, although relevant to statute of limitations and perhaps allocation of liability for cumulative injury under Labor Code § 5500.5, Labor Code 5412 is not determinative of whether employee sustained one or two cumulative injuries. Roger Bass v State of California, Dept. of Corrections & Rehabilitation 82 Cal Comp Cases 1034, 2017 Cal.Wrk.Comp. P.D. LEXIS 213 (BPD); [See generally Hanna, Cal.Law of Emp.Inj. and Workers' Comp. 2d §4.01[2][a], Rassp & Herlick, California Workers' Compensation Law, Ch. 10, § 10.06[1].]

Permanent Disability—Rating—Combined Values Chart—WCAB concluded that whether disability should be added to combined is a medical issue. Roger Bass v State of California, Dept. of Corrections & Rehabilitation 82 Cal Comp Cases 1034, 2017 Cal.Wrk.Comp. P.D. LEXIS 213 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp 2d §§8.02[3, [4][a], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation, Ch. 6.]

Insurance Fraud—Benefits Awarded Despite Fraud—Surveillance video of Applicant's established false exaggeration of the extent of his disability, and resulting in applicant pleading guilty to one count of violating Insurance Code § 1871.4, held did not bar applicant's entitlement 70% PD award per the AME where the benefits were not "owed or received as a result of a violation of Section 1871.4 ... for which the recipient of the compensation was convicted, and thus the exaggeration did not affect applicant's actual entitlement to benefits. Ford v. Workers' Comp. Appeals Bd., (4thAppellate District) 82 Cal. Comp. Cases 1105, 2017 Cal. App. Unpub. LEXIS 6899; See also, Tensfeldt v. WCAB (1998) 66 Cal.App.4th 116 [77 Cal. Rptr.2nd 691; Farmers Ins. v. WCAB (2002) 104 Cal.App.4th 684 [128 Cal.Rptr.2d 353]. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 2.03[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 11, § 11.30[2], [3].]

Trial – Procedure -- Testimony by Applicant – A deported applicant may testify by "FaceTime" (cell phone) where the applicant's identity is authenticated. Vargas v. Becker Construction and Ace Private Risk(decision after reconsideration) (August 2017) 45 CWCR 182.

Psychiatric Injury – Compensable Consequence – Violent Act -- A 20-foot fall from a tree by a tree trimmer who landed on his head and suffered a psychiatric injury held to constitute a "violent act" exception that permits compensation under L.C. § 4660.1(c)(2)(A); A "violent act" pursuant to L.C. § 4660.1(c)(2)(A) is not limited to criminal conduct. Torres v. Greenbrae Management/SCIF (July 2017) 45 CWCR 152 (writ den.); See also, Larsen v. Securitas Security Services (2016) 44 CWCR 111, and Madson v. Michael J. Covaletto Ranches (Zenith Ins. Co.) (2017) 45 CWCR 65

Compensable Consequence – Sexual and Sleep Disorder – A sexual and sleep disorder analysis under Almaraz/Guzman as an add-on is impermissible under § 4660.1 as an attempt to circumvent the legislative

intent to exclude compensation for the secondary consequences of sleep and sexual disorder. Torres v. Greenbrae Management/SCIF (July 2017) 45 CWCR 152 (writ den.)

Claims for Discrimination, Harassment, and Retaliation – Workers' Compensation Proceedings – Fair Employment and Housing Act Proceedings – Res Judicata – Res judicata barred plaintiffs' claim against employer pursuant to Fair Employment and Housing Act, Government Code § 12900 et seq., where WCJs in workers' compensation proceedings denied plaintiffs' claims for psychiatric injury after finding that employer's action were non-discriminatory, good faith personnel decisions. Ly v. County of Fresno (9-15-17) (Fifth Appellate District), 82 Cal Comp Cases 1138; 2017 Cal. App. LEXIS 882. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 21.08[2][b], [d]; Rassp & Herlick, California Workers' Compensation Law, Ch. 11, § 11.27[14], Ch. 20, § 20.03[3].]

Statute of Limitations – Tolling – Where the applicant filed worker's compensation claim against uninsured employer contractor and not owner of premises where he was working at time of injury, and where applicant knew of the potential liability of an entity other than the named target employer, the statute of limitation was not tolled against the unnamed entity while the issue of employment was being litigated against the named entity. Bolanos v WCAB (Jimenez) (10/3/2017) 82 Cal Comp Cases 1097, 2017 Cal.App.Unpub. LEXIS 6890; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 24.02, 24.03[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 14, §§ 14.01[4], 14.16, 14.17.]

Subsequent Injuries Benefits Trust Fund – Commencement of Benefits – Subsequent Injuries Benefits Trust Fund benefits commence at time employer's obligation to pay permanent disability benefits begins, and pursuant to Labor Code § 4751 such benefits were mandated to begin on the day after temporary disability payments ceased, and not necessarily when applicant becomes P&S. Baker (as SIBTF administrator) v. WCAB (Guerrero), July 28, 2017, 82 Cal Comp Cases 825, 13 Cal. App. 5th 1040, 2017 Cal.App. LEXIS 662; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 31.20[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 8, § 8.03.]

Permanent Disability—Rating—Rebuttal of Scheduled Rating—Consistent with of *Contra Costa County v. W.C.A.B. (Dahl)* (2015) 240 Cal. App. 4th 746, 193 Cal Rptr. 3d 7, 80 Cal. Comp. Cases 1119, the scheduled rating, while presumptively correct, may be rebutted by evidence providing individualized assessment of whether industrial factors limit applicant's ability to benefit from vocational rehabilitation, and here reports of applicant's treating psychologist, the AME and testimony of VR expert and applicant were sufficient to rebut scheduled rating of permanent disability. CompWest Insurance Company v WCAB (Gonzales) (2nd Appellate District) 82 Cal Comp Cases 897, 2017 Cal.Wrk.Comp. LEXIS 54 (WD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4], 32.02[2], 32.03A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation, Ch. 8.]

Discovery-Closure-Removal denied where order closing discovery pursuant to Labor Code § 5502(d)(3) was determined that defendant had ample opportunity and failed to obtain additional qualified medical evaluator panels to contest issue of extent of psychiatric and internal permanent disability and failed to timely object under Labor Code § 4062 to opinions of primary and secondary/consulting treating physicians regarding psychiatric and internal parts of body being industrially injured, thereby waiving its objection. Willis v. The Kroger Company dba Food 4 Less, 2017 Cal. Wrk. Comp. P.D. LEXIS 526 (BPD). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 26.03[4], 26.04[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1], Ch. 19, § 19.37; Sullivan on Comp, Section 15.25, Declaration of Readiness to Proceed.]

Utilization Review — Independent Medical Review — WCAB Jurisdiction — Medical Treatment Utilization Schedule —WCAB has no jurisdiction over whether utilization review and independent medical review had used correct standard, where IMR reviewer arguable corrected but upheld UR basis for denial of further RFA for additional acupuncture treatments holding that whether utilization reviewer correctly followed medical treatment utilization schedule is question directly related to medical necessity and,

therefore, is reviewable only by independent medical review; Court of Appeal also held that independent medical review does not violate state separation of powers or due process and does not violate federal procedural due process citing and following Stevens v. WCAB (2015) 241 Cal.App.4th 1074 [194 Cal.Rptr. 3d 469. Ramirez v. Workers' Comp. Appeals Bd., 10 Cal. App. 5th 205, 215 Cal.Rptr.3d 723, 82 Cal.Comp.Cases 327, 2017 Cal.App. LEXIS 282; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.02[1], [2][a]-[d]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11.]

Workers' Compensation Insurance Policies — Rescission — Employer's Misrepresentations — A policy of workers' compensation insurance may be rescinded (Insurance Code 650) effective retroactively based on fraud under Civ. Code 1691, by giving notice of rescission and restoring, or offering to restore, everything of value received under the contract and any party to the contract may seek legal or equitable relief based upon the rescission pursuant to Civ. Code 1692. Southern Ins. Co. v. Workers' Comp. Appeals Bd., 11 Cal. App. 5th 961, 217 Cal.Rptr. 3d 898, 82 Cal.Comp.Cases 448, 2017 Cal.App. LEXIS 457. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 2.61[2]; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, § 3.24[2].]

Injury AOE/COE—Injury From Work Stress—Physical vs. Psychiatric Injury—Heart attack death caused by 10% industrial stress held industrial where WCAB reasoned that when stress causes physical injury occurs that Labor Code § 3208.3 does not apply, that Labor Code § 3208.3 applies only to physical injuries that are solely caused by psychiatric injury as described in *County of San Bernardino v. W.C.A.B. (McCoy)* (2012) 203 Cal. App. 4th 1469, 138 Cal. Rptr. 3d 328, 77 Cal. Comp. Cases 219; And pursuant to *McCoy* defendant has burden of proof of establishing that applicant's heart attack was caused solely by non-compensable psychiatric injury so as to avoid liability for death benefits. Xerox Corporation v. WCAB (Schulke)(2nd Appellate District) 82 Cal. Comp. Cases 273, 2017 Cal.Wrk.Comp. LEXIS 13; See also, accord, Wang v. Southern California Edison (2015) 2015 Cal.Wrk.Comp. P.D. LEXIS 511 (BPD) [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 4.02[3], 4.68[1]-[3], 4.69; Rassp & Herlick, California Workers' Compensation Law, Ch. 10, §§ 10.04[1], 10.06[3][d].]

Medical Treatment-Utilization Review-Disputed Injuries- Applicant entitled to UR approved treatment where defendant failed to act timely within five-day timeframe in 8 Cal. Code Reg. 9792.9.1(b)(1) to defer liability for recommended treatment, and where defendant decided to proceed with UR rather than defer, it cannot later decide to delay medical treatment approved by UR on basis that it is disputing industrial injury; Since defendant in this case accepted liability for applicant's neck injury and recommended surgery was certified by UR there was no basis for defendant's failure to authorize surgery. Mata v. Supermercado Mi Tierra, 2017 Cal. Wrk. Comp. P.D. LEXIS 166 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11.]

Temporary Disability—Medical Treatment—Delay —Applicant found P&S despite authorized tens unit or surgery where applicant not creditable at trial on explanation for delay. Clavreul v. Glendale Adventist (BPD) 45 CWCR 40.

Cumulative Trauma and Apportionment of Liability

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CUMULATIVE TRAUMA

LC 3208.1 - INJURIES SPECIFIC OR CUMULATIVE (CT)

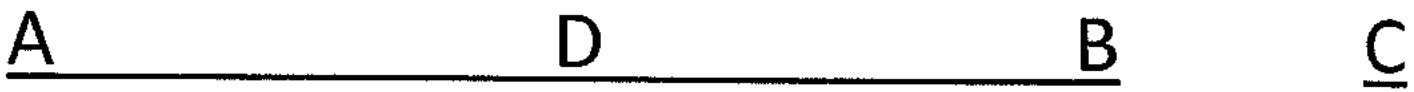
LC 5412 - DATE OF INJURY OCCUPATIONAL DISEASE OR CUMULATIVE INJURY;

A- KNOWLEDGE

B- DISABILITY

LC 5500.5 - LIABILITY LAST YEAR OF HAZARDOUS EXPOSURE

TIME LINE



A= START OF EMPLOYMENT

B= END OF EMPLOYMENT

CUMULATIVE TRAUMA INJURY
&
THE RELEVENCE OF DOI

The Statute Of Limitations
Entitlement To Benefits
Apportionment Of PD
The Liability Between Co-Defendants

The following represents a summary of the law of Cumulative Trauma Injuries and the Statute of Limitation as related to CT Injuries. This discussion includes relevant statutes and case decisions issued by the California Supreme Court, California Court of Appeal, and the Workers' Compensation Appeals Board, which the Editor believes are of significance in connection with these topics. The summaries are only the Editor's interpretation, analysis, and legal opinion, and the reader is encouraged to review the statute and/or original case decision in its entirety.

Practitioners should proceed with caution when citing to this panel decision and should also verify the subsequent history of the decision. WCAB panel decisions are citable authority, particularly on issues of contemporaneous administrative construction of statutory language [see Griffith v. WCAB (1989) 209 Cal. App. 3d 1260, 1264, fn. 2, 54 Cal. Comp. Cases 145]. However, WCAB panel decisions are not binding precedent, as are en banc decisions, on all other Appeals Board panels and workers' compensation judges [see Gee v. Workers' Comp. Appeals Bd. (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cases 236]. While WCAB panel decisions are not binding, the WCAB will consider these decisions to the extent that it finds their reasoning persuasive [see Guitron v. Santa Fe Extruders (2011) 76 Cal. Comp. Cases 228, fn. 7 (Appeals Board En Banc Opinion)]. Panel Decisions which are designated as "Significant" by the WCAB, while not binding in workers compensation proceedings, are intended to augment the body of binding appellate court and en banc decision and is limited to panel decisions involving (1) issue(s) of general interest to the workers' compensation community, especially a new or recurring issue about which there is little or no published case law; and (2) upon agreement en banc of all commissioners on the significance and importance of the issues presented and resulting decisions. (See Elliot v. WCAB (2010) 182 Cal.App. 4th 355, 361, fn. 3, 75 CCC 81; Larch v. WCAB (1999) 64 CCC 1098, 1099-1100 (writ denied).

I. Cumulative Trauma Injury Defined.

An industrial "Cumulative Trauma Injury" is when a number of minor industrial stressor occur over a period of time resulting in an eventual injury. The seminal decision defining "Cumulative Trauma Injury" is *Beveridge v. IAC, (1959) 175 CA2nd 592, 24 CCC 274,* which provides that *"while a succession of slight injuries in the course of employment may not in themselves be disabling, their cumulative effect in work effort may become a destructive force. The fact that a single but slight work strain may not be disabling does not destroy its causative effect, if in combination with other such strains, it produces a subsequent disability. The single strand, entwined with others, makes up the rope of causation."*

"The fragmentation of injury, the splintering of symptoms into small pieces, the atomization of pain into minor twinges, the piecemeal contribution of work-effort to final collapse, does not negate injury. The injury is still there, even if manifested in disintegrated rather than in total, single impact. In reality, the only moment when such injury can be visualized as taking compensative form is the date of last exposure, when the cumulative effect causes disability".

§ 3208.1. "Specific" and "cumulative" injuries, provides "An injury may be either: (a) "specific," occurring as the result of one incident or exposure which causes disability or need for medical treatment; or (b) "cumulative," occurring as repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment. The date of a cumulative injury shall be the date determined under Section 5412."

§ 5412. Date of injury; Occupational disease or cumulative injury, provides "The date of injury in cases of occupational diseases or cumulative injuries is that date upon which the employee first suffered disability therefrom and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment."

§ 5500.5. Employer liability for occupational disease or cumulative injury; Apportionment, provides ". . . Commencing January 1, 1979. . . liability shall be imposed upon the last year of employment exposing the employee to the hazards of the occupational disease or cumulative injury for which an employer is insured for workers' compensation coverage or an approved alternative thereof." See also, Colonial Ins. Co. (Pedroza) (1946) 29 Cal.2nd 79, 11 Cal.Comp.Cases 226.

See also, relevance of CT date of injury, on (1) Statute of Limitations: Chambers v. WCAB 33 CCC 722, Chavira v. WCAB 56 CCC 631; (2) Indemnity rate: Solar Turbines v. WCAB (Gurfinkel) 72 CCC 519; (3) Dependency status: State of California, Dept. of Highway Patrol v. WCAB (Sills) 60 CCC 308; (4) Petitions to Re-open: Palmer v. WCAB 52 CCC 298.

Simply stated, the date of industrial cumulative trauma injury for determination of applicant's entitlement to benefits (DOI for Statute of Limitations, indemnity rate, dependence status) requires the concurrence of (1) "injurious industrial activities", events or exposure which (2) results in "disability" and (3) upon "knowledge or reason to know the existence of a cause and effect relationship between the Injurious Industrial activities and the resulting disability".

The Date of Cumulative Trauma Injury is important for Statute of Limitations under LC 5405, the Rate of Indemnity, Dependency Status, and timeliness of petition to re-open. However, while the date of injury pursuant to LC 5412 is controlling on applicant's entitlement to benefits, it is not determinative on the issue of apportionment of liability between co-defendants.

A. What Constitutes "Disability"

"Disability" necessary for date of CT injury has been defined as "an impairment of bodily function which results in the impairment of earning capacity" which has generally been interpreted as requiring the existence of PD or TD. While the need for medical treatment is relevant for consideration it is not determinative on the issue. (See generally, *Chavira v. WCAB 56 CCC 631, Thorp, Inc. v. WCAB (Butler) 49 CCC 228; Lorenz v. Encino Hospital Medical Center, 2014 Cal.Wrk.Comp.P.D. LEXIS 410; SCIF v. WCAB (Rodarte) 69 CCC 579.*)

B. "Knowledge or Reason to Know"

As a general rule, knowledge that the "disability" was caused by an injurious industrial exposure, events or activities will require a medical opinion. (See, *City of Fresno v. WCAB (Johnson)50 CCC 53; Pacific Indemnity Co. v. IAC (Rotondo) 15 CCC 3; LA Fire Dept. v. WCAB (Johns) 75 CCC 755 (Writ Denied).)* It is the defendant/employer who has the burden of proof on the issue of knowledge. (See, *Chambers v. WCAB 33 CCC 722.)*.

II. Cumulative Trauma and the Statute of Limitations/Entitlement to Benefits

Jack in the Box v. WCAB (Abel) (Court of Appeal, 1st Appellate District, 2004) 69 CCC 511.

> *See also, Estrella v. Milwaukee Brewers and San Francisco Giants (W/D) 81 C.C.C. 525, split panel decision, holding professional baseball pitcher's cumulative trauma injury for period ending 2004, filed 2013 was barred by one-year statute of limitations in Labor Code § 5405, where applicant knew or should have known of his right to file workers' compensation claim and suffered disability for purposes of Labor Code § 5412 date of injury more than one year before claim was filed, based on evidence that (1) applicant had actual knowledge of his right to seek workers' compensation benefits evidenced by prior 2007 claim; and (2) applicant's testimony that he made correlation between his orthopedic symptoms forcing retirement and his employment as professional baseball player; and statute of limitations not tolled by defendants' failure to provide applicant with actual notice of his workers' compensation rights pursuant to Reynolds v. W.C.A.B. (1974) 12 Cal. 3d 726, 117 Cal. Rptr. 79, 527 P.2d 631, 39 Cal. Comp. Cases 768, where no evidence such as medical records/reports or team records indicating that defendants knew of applicant's cumulative injury. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 24.03[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 14, §§ 14.13[1], 14.16.]*

Applicants were the wife and son of the decedent who died of a myocardial infarction at a time when decedent was employed as the loss prevention manager with defendant, Jack in the Box. Decedent had been employed with Jack in the Box from 7/14/98 to 4/20/01. Applicant had previously been employed as a police officer from 1/1/78 to 1/17/96 for the City of Emeryville. No evidence was established showing disability (ie. loss of time from work or medical treatment) occurring during applicant's employment with the City of Emeryville.

> *". . .A single cumulative trauma injury may not be found when there are two distinct periods of disability and need for medical treatment during separate employment exposures. . .the Board held that a cumulative injury during the first employment must result in disability, not just medical treatment, to constitute a separate injury to prevent application of the last year of exposure as provided in Labor Code section 5500.5 . . . We note that the appellate court has held that when there are two periods of temporary disability linked by continued need for medical treatment, a single cumulative injury may be found. (Western Growers Ins. v. WCAB (Austin) (1993) 58 CCC 323.) . . ."*
>
> *Jack in the Box v. WCAB (Abel) (Court of Appeal, 1st Appellate District, 2004) 69 CCC at pg. 514.*
>
> *Editor's Comments: The take away in the Jack in the Box decision is that the injurious exposure appears to have continued into the applicant's subsequent employment with Jack in the Box there by extending forward the last year of CT under LC 5500.5.*

The WCJ issued a Joint and Several F&A finding two separate CT's during each period of employment. The WCAB reversed the WCJ applying LC 5500.5 and finding a single CT during applicant's employment with Jack in the Box.

The Court of Appeal upheld the WCAB noting that when a CT injury extends over a worker's entire employment history, liability for an injury is limited to employers who employed the worker during the one year immediately preceding the earlier of two dates: the date of injury as determined under Labor Code Section 5412, or the last date on which the worker was employed in an occupation exposing him to the hazards of the disease or injury. The Court went on to highlight the complete lack of evidence establishing any disability during applicant's employment with the City of Emeryville.

> *See also, Simmons v. County of Riverside, 2016 Cal.Wrk.Comp. P.D. LEXIS 442 (BPD) holding that sheriff entitled to LC 3212.5 heart presumption despite prior cardiovascular condition as he did not develop hypertrophic cardiomyopathy until well into his employment and the WCAB found this heart trouble developed or manifested while he was in the service of the sheriff department. Further because LC 3212.5 presumption applies the PD was not subject to apportionment pursuant to LC 4663(e).*

Delta Dental Plan of California v. WCAB (Funk) (2014) 79 CCC 954, 2014 Cal.Wrk.Comp. LEXIS 95.

Applicant claimed injury for the period ending 11/9/01which she failed to file a claim form until 6/11/03. Defendant denied the injury as barred by LC 5400 which defendant argued requires an injured employee to give notice to the employer within 30 days after the occurrence of the injury. At trial the applicant's supervisor testified that she had had a conversation with a co-manager in which she understood that the co-supervisor/manager "thought" the applicant "might have suffered an industrial injury". The issue was whether this was sufficient information to trigger defendant's duty to provide applicant with a claim form and if not doing so acted to toll the statute of limitations. Other relevant evidence included that the applicant in her position as a manager she knew of her workers' compensation rights, and that information of the possibility of an industrial injury from a co-manager was insufficient to trigger the duty to provide a claim form.

The WCJ held for the applicant, determining that the employer's duty to provide the claim form arises upon receipt from any source that the applicant potentially sustained an industrial injury. There is no requirement under LC5401 that the information of injury come directly from the applicant. In this case the employer had sufficient information to trigger the duty for the employer to provide the claim form. Failure to do so prevents the employer from asserting the bar under LC 5400/5401.

Editor's Comments: The decision in Delta Dental Plan was limited to the issue of whether the claim was barred by the statute of limitations under LC sections 5400/5401. Once the duty to provide a claim form arises and the employer fails to provide the claims form, the employer is estopped to assert the statute of limitations as a bar to the claim. This decision did not address the companion issue of whether the presumption of compensability under LC 5402 applies where defendant failed to accept/reject/delay within 90 days of knowledge of an industrial injury. See, Muna v. WCAB (2007) 35 CWCR 263, 72 CCC 1219; City of Merced v. WCAB (Fenton) (2005 5th Appellate District) 2005 Cal. App. Unpub. LEXIS 4671, 33 CWCR 127; Janke v, WCAB (1991) 19 CWCR 310 (Panel Decision); But see, limiting, Honeywell v. WCAB (12/20/02) (Court of Appeal, 2nd Appellate District) 67 CCC 1557.

A companion issue in application of the Statue of Limitations to CT injuries pursuant to LC sections 5405 and 5412 one year form date of injury with the date of injury being the concurrence of disability with knowledge or reason to know that the disability was caused by an injurious industrial exposure. See Technicolor, Zurich American Insurance v. WCAB (Minichiello-Smith) 79 CCC 1581, 2014 Cal.Wrk.Comp. LEXIS 167. See also, Salas v IDS USA West 2014 Cal.Wrk.Comp. PD LEXIS 364 where the Statute of Limitation for cumulative trauma injuries was not date undocumented worker was terminated for being undocumented but rather several weeks later when PTP first reported need for job modification due to industrial CT injury. See also, Thompson v. Huhtamaki Americas, Inc. 2014 Cal.Wrk.Comp.PD LEXIS 533 where claim for death from asbestos was barred where injury known inter vivos and application for death claim not filed by widow within one year of death.

Earthgrains Co. v. WCAB (Hansen) (2008) 36 CWCR 168, 73 CCC 1000 (Not Certified for Publication)

Applicant sustained three injuries over a 14-year period of employment as a route salesman. All three were specific and resulted in stipulated awards, one on the right knee and two for his back. Applicant retired sometime in 2002, due to low back surgery. Applicant filed a new claim of cumulative trauma injury in 2005. Defendant denied injury, asserting the Statute of Limitations. At trial, the applicant testified that he had no understanding of cumulative trauma injury, or that it's worsening condition might have been caused by a CT injury until, he met with his attorney in May of 2005. Defendant introduced a report of the treater, dated 9/01, which suggested a CT injury.

The WCJ found for the applicant, awarding two years of retro-active TD and an additional 49% PD. Supporting his opinion, the WCJ noting the first knowledge of a CT injury according to the applicant's testimony, was when he met with his attorney in May of 2005. The WCJ noted that the 9/01 treater's report was only sent to the Defendant and no evidence was presented that the applicant was provided or was ever aware of the treater opinion which suggested a CT injury. The Court held that a CT injury required the concurrence of injurious industrial exposure, disability with knowledge or reason to know that the injurious exposure was causative of the disability. Here no evidence existed placing all elements required for a CT injury, until the applicant met with his attorney in May of 2005. The Court also stated that where the defendant has evidence of CT injury, the defendant has the duty to provide a claim form. Therefore, the claim was not barred by the statute of limitations.

Roger Bass v State of California, Dept. of Corrections & Rehabilitation 82 Cal Comp Cases 1034, 2017 Cal.Wrk.Comp. P.D. LEXIS 213 (BPD)

Editor's Comments: The decision of Bass v. State of California, Dept. of Corrections is important for two reasons. First, this is the first reported decision that expressly prohibits the WCJ from deciding whether or not to apply the CVE. In the absence of medical evidence on this issue it appears the WCJ must either apply the CVE or perhaps request further development of the medical record. Second, although separate parts or conditions may be injured, where the injurious period in the same, a single CT injury will be found. Here however, if the defendant had established that the injurious exposure for orthopedic injury was different from that of the injury to heart, the result might have been different.

Apportionment of Liability as between co-defendants again applies the doctrine of "Substantial Evidence" but is a hybred of the elements of "strict legal apportionment" and "Date of CT Injury. Apportionment of liability starts with an analysis to determine the Date of CT injury. Here the focus in on "injurious exposure/activity" and the documented consequence. Here the physician is expected through review of medical records, deposition transcripts, and review of job descriptions, to allocate liability among co-defendant who are either sharing the period of CT or are responsible for successive CT industrial injuries. This analysis is factually dependent and requires the reporting physician to use in equal parts medical knowledge, factual/medical information, and common sense. The primary consideration by the evaluating physician should focus on the physical arduousness of the industrial activity, and/or the intensity of the exposure/stressor in addressing the allocation of liability for the subject injurious exposure/activity period or periods. It is the evaluating physician's analysis that is the most important component to apportionment of liability as between co-defendants.

The first step in the analysis is to determine the date of CT injury: (1) Injurious industrial exposure, (2) Disability and (3) applicant's knowledge or reason to know the existence of a cause and effect relationship.

The second step is: Did the last date of "injurious exposure" occur before or after the "Date of CT Injury". If the "injurious exposure" ended before than the "Date of CTinjury", than liability would be on the carrier on the risk during the year ending with the ending of the "injurious exposure/activity/stressor". If the injurious exposure continued beyond "Date of CT Injury" than liability as between co-defendants would be the year period ending upon "Date of CT Injury".

Applicant, a correctional officer for over 30 years, sustained a CT injury for the period ending 7/15/14, to heart, neck, low back, right knee, and left foot. Although Applicant continued to work in his normal and customary job without restriction, he received treatment provided by the employer for a number of years to chronic neck, low back, right knee, and left foot pain. Although the parties stipulated that the orthopedic injuries and injury to heart were the result of a single cumulative injury, the defendant's contended that since the disease process for each type of injury was from different causes, there should be two separate awards, one for orthopedic injury, and one for injury to heart. After trial the WCJ held a single CT, and an awarded PD without application of the CVE, merely adding the disability for the orthopedic injury to the disability for the injury to heart.In upholding the WCJ, the WCAB held that even though there were two different dates of injury under Labor Code § 5412 for applicant's heart and orthopedic injuries, there was a single period of injurious exposure for purposes of determining liability under Labor Code § 5500.5. Further, that while the date of injury under Labor Code § 5412 has relevance to statute of limitations and perhaps allocation of liability for cumulative injury under Labor Code § 5500.5, it does not determine whether employee sustained one or two cumulative injuries. Here the WCAB held a single period of injurious industrial exposure was responsible for both injury to spine, right knee/left foot, as well as to heart. As to whether the disability should be added or the CVE should be applied, the WCAB held that this was a medical question and because the medical record was silent on the issue the matter was remanded for development of the medical record.

III. Cumulative Trauma Injuries and Apportionment of Causation of Disability (LC 4663)

Strict legal apportionment of causation of disability under LC 4663 has the same requirements whether involving successive specific industrial injuries, successive cumulative injuries, a combination of specific and cumulative injuries, or to non-industrial causation.

The requirements for strict legal apportionment of PD is a substantial evidence analysis involving the doctrine of direct causation. The doctrine of "Substantial Evidence" as applied to apportionment to causation of disability requires that the medical report and resulting opinion be based on a (1) full, complete, and accurate medical history with a proper diagnosis; (2) be based on reasonable medical probability within the physicians education, training and experience, and the facts involved in the case; and (3) that the physician "explain the how and why", "connect the dots", "apply the factual and medical evidence to the law to support the opinion". The analysis and discussion by the physician should focus on the "severity" of injury, pathology, symptomatology, and treatment.

The doctrine of "Direct Causation" provides that the employer is only responsible for that portion of the PD which is the "direct result" of the subject injury. This writer would suggest that "direct causation" requires that the industrial PD must be the direct, sole and exclusive result of the subject industrial injury.

Best Buy Company v. WCAB (Nquyen) (2012) 77 CCC 1128 (Writ Denied)

Applicant sustained CT injury for the period ending 8/20/01 and alleged a specific injury as the result of a motor vehicle accident occurring on 8/20/01. Injury was to neck, low back, bilateral legs/feet, gastrointestinal disorder, and hypertension. At the time of both injuries the applicant was employed as a repair technician with Best Buy. The parties selected Dr. Alban as the AME who opined that 20% of the applicant's disability to cervical and lumbar spine was attributable to "continuing trauma at home" or "non-industrial cumulative trauma", and that 50% of the applicants heel condition was apportioned to "non-industrial weight bearing". The AME provided no further explanation or rational for his apportionment to non-industrial causation. Further, the AME found separate dates of injury for the specific and CT as alleged.

The WCJ award refused to follow the opinion of the AME finding only a single CT injury which caused 100% PD without apportionment.

On reconsideration by split panel decision the decision of the WCJ was upheld. First, the Board noted that the AME's report "failed to adequately support his determination with specific explanations of the contributory nature of the non-industrial activities". The Board also held the WCJ properly exercised his role as the trier of fact in making his determination that the specific was merely part of the CT injury rather than a separate injury.

". . .We observe, additionally, that while the AME concluded that there were non-industrial factors that caused some of applicant's permanent disability, his reports fail to adequately support his determination with specific explanations of the contributory nature of the non-industrial activities. The AME's opinion is only valid to the extent he identifies and explains the facts that support it. . .the AME failed to identify the facts that demonstrate how the non-industrial factors caused the disability. . .Nowhere in his opinions does [the AME] explain his attribution of disability to 'continuing trauma at home' in that he does not specify how and why applicant's activities of daily living contributed to the extent of his disability."

Editor's comments: This decision could have easily gone for the defendant if the defendant had merely sought clarification from the AME regarding the evidentiary basis for his opinion on apportionment such as the lack of or level of treatment just prior to the MVA; Facts related to the MVA such as speed, whether applicant was safety belted, and vehicle damage; Specific non-industrial ADL's which the applicant was engaging and how they impacted on, contributed to and directly caused the subject disability.

See also, Piper v. WCAB (2012) 77 CCC 661 (Writ Denied) where surveillance video in conjunction with the presence of severe degenerative changes to right knee supported WCJ's finding of less than total disability which was (1) contrary to the testimony of VR expert and (2) consistent with apportionment to successive industrial injuries and non-industrial causation.

See also, Slagle v. WCAB (Department of Corrections) (2012) 77 CCC 467 (Writ Denied) which held that the use of age to support opinion that pathology, (degenerative changes in knee), existed in part due to non-industrial causation, was valid legal apportionment under LC 4663, and not invalid age discrimination, despite relationship between age and degenerative changes where degenerative changes were objectively demonstrative within the applicant's medical records.

Yellow Transportation v. WCAB 71 CCC 1473 (Writ Denied)

Applicant sustained injury on 7/10/98 and a CT for period ending 6/29/00 to various parts of body. The applicant had prior claims on 3/87 to back and 10/10/87 to neck. All injuries were with the same employer. The parties entered into an AME who opined that 1/3 was due to degenerative changes; 1/3 to 1987 and the resulting natural progression; 1/3 due to the CT. The WCJ refused to follow the AME finding in that it did not comply with *Escobedo* in that it was not substantial evidence. A key fact seemed to be that although c-spine x-rays taken on 6/2/95 revealed marked degenerative changes, the AME did not himself

. . . "the WCJ stated that there was no requirement that she adopt all of the AME's opinion, as long as she states her reasons for rejecting parts of it. With regard to apportionment, [the WCJ noted that Escobedo] requires that a medical opinion be based on reasonable medical probability. [The WCJ] also noted that in his 11/30/04 deposition, [the AME] stated, ***"I think the 'fairest' overview would be one-third to the '87 injury,*** *one-third to the existence of these degenerative changes, and one-third to the June trauma after the condition became symptomatic. . .The WCJ pointed out that although [the AME] explained the nature of Applicant's degenerative changes, he did not explain* ***how or why*** *these changes were responsible for one-third of Applicant's disability. Moreover, the WCJ noted that [the AME] did not explain why the very heavy work Applicant performed in his employment was responsible for only one-third of the Applicant's PD. Under the circumstances, the WCJ did not believe that a 'fair' apportionment was the same as apportionment based on reasonable medical probability and felt that [the AME] had picked the percentage of PD '****off the top of his head'.****" (At page 1475)*

"The apportionment set forth by the AME is speculative and not based upon reasonable medical probability. He specifically gives no reasoning as to why he picked 1/3 of the PD, rather than another fraction, to apportion to each factor, that is, the prior 1987 injury, the degenerative findings/activities of daily living, and the cumulative trauma. Further, [the AME] relies upon 1995 cervical X-ray findings, which are contradicted by the 1995 cervical MRI. . ." (At page 1477).

review the actual films, and an MRI taken six weeks later on 7/11/95 revealed only minimal bulging at the C3-4 and C5-6 levels without degenerative changes. Further, the MRI of 3/22/00 was interpreted without evidence of herniation, canal stenosis, or forminal encroachment. It was only the MRI taken two years later, on 3/26/02 which showed degenerative disc disease.

Recon denied. Writ Denied

Dufresne v. Sutter Maternity & Surgery Center of Santa Cruz (2014) 2014 Cal.Wrk.Comp. P.D. LEXIS 710

Applicant was a registered nurse who sustained successive injuries to thoracic spine on 2/22/99, 4/7/04/ and CT ending 4/7/04. Additionally, applicant had prior nonindustrial injury and resulting surgeries to low back and neck. The applicant did settle with co-defendant via C&R that defendant's liability for injury to thoracic spine. The parties agreed to use AME's for both the physical and psychiatric injury. Dr. Fugimoto, who reported as the AME on the physical component authored numerous reports in addition to being deposed. In the end it was his opinion that due to "(1) a combination of her musculoskeletal injuries (i.e., chronic thoracic, cervical, and low back pain) and her psychiatric issues that preclude applicant from working in the open labor market; (2) her inability to return to the open labor market is 80% caused by the industrial injuries and 20% by the nonindustrial injuries; and (3) it is the "synergistic effect" among her psychiatric and musculoskeletal injuries (industrial and nonindustrial injuries) that render her incapable of employment on the open labor market. . .Dr. Fujimoto said that applicant could compete in the open labor market based upon her thoracic spine symptoms alone. He said, however, that he could not comment on whether the psychiatric issues by themselves would preclude her from competing on the open labor market."

Dr. Alloy, who reported as the psych AME, also authored numerous reports and was also deposed. In the end, AME Alloy found apportionment as follows: 75% industrial/ 25% nonindustrial and of the 75% industrial he would apportion 80% thoracic (which appears to relate to the 1999 industrial injury), 10% low back (non-industrial injury later associated with the

"It is true that apportionment of permanent disability has been held to be impermissible in cases where an industrial injury gives rise to a conclusive presumption of permanent total disability under section 4662. (E.g., City of Santa Clara v. Workers' Comp. Appeals Bd. (Sanchez) (2011) 76 Cal.Comp.Cases 799 (writ den.) (under § 4662(d), employee was conclusively presumed to be permanently totally disabled because he had sustained an "injury to the brain resulting in incurable mental incapacity or insanity"); Kaiser Foundation Hospitals v. Workers' Comp. Appeals Bd. (Dragomir-Tremoureux) (2006) 71 Cal.Comp.Cases 538 (writ den.) (under § 4662(b), employee was conclusively presumed to be permanently totally disabled because she had lost the use of both hands).) However, applicant's case does not involve a conclusive statutory presumption of permanent total disability. Moreover, we conclude that apportionment is permissible in cases where permanent total disability has been determined "in accordance with the fact" under section 4662. Section 4663(a) expressly provides that "[a]pportionment of permanent disability shall be based on causation" and section 4664(a) expressly provides that "[t]he employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment." Also, in Brodie v. Workers'Comp. Appeals Bd. (2007) 40 Cal.4th 1313, 1327–1328 [72 Cal.Comp.Cases 565], the Supreme Court observed that sections 4663(a) and 4664(b) create a "new regime of apportionment based on causation" and it held that "the new approach to apportionment is to look at the current disability and parcel out its causative sources-nonindustrial, prior industrial, current industrial-and decide the amount directly caused by the current industrial source." (See also, e.g., Acme Steel v. Workers' Comp. Appeals Bd. (Borman) (2013) 218 Cal.App.4th 1137, 1142–1143 [78 Cal.Comp.Cases 751] (Borman); Benson, supra, 170 Cal.App.4th at pp. 1548, 1559.)."

". . ..unless an injured employee's overall permanent total disability is predicated on a conclusive statutory presumption under section 4662, the apportionment to causation language of sections 4663(a) and 4664(a) and the case law interpreting these statutes provide that an employee's permanent disability must be apportioned based on its causative sources, even if the overall disability is 100%. (§§ 4663(a), 4664(a); Brodie, supra, 40 Cal.4th at pp. 1327–1328; Borman, supra, 218 Cal.App.4th at pp. 1142–1143; Benson, supra, 170 Cal.App.4th at pp. 1548, 1559.) The injured employee has the burden of affirmatively establishing the extent of his or her permanent disability. (§§ 3202.5, 5705.) Thereafter, however, the burden shifts to defendant to prove apportionment. (Pullman Kellogg v. Workers' Comp. Appeals Bd. (Normand) (1980) 26 Cal.3d 450, 456 [45 Cal.Comp.Cases 170]; Kopping v. Workers'Comp. Appeals Bd. (2006) 142 Cal.App.4th 1099, 1115 [71 Cal.Comp.Cases 1229]; Escobedo v. Marshalls (2005) 70 Cal.Comp.Cases 604, 613 (Appeals Board en banc) (Escobedo).)"

Editor's Comment: Dufresne provides a well written and reasoned opinion on the interplay between burden of proof and direct causation in the context of a Labor Code 4663/4664 analysis. The reader should take away from this opinion the fact that regardless of the theory of establishing a permanent disability award, e.g., "Standard AMA rating, ""Guzman," "Ogilivie/LeBouef," or 4662, the disability award will be limited to the whole person impairment and resulting disability which is solely, exclusively, and directly caused by the subject industrial injury.

See also, NBC Universal Media v. WCAB (Moussa) 79 CCC 191 (W/D) which upheld the WCJ's right to apportion based on "range of the evidence" where WCJ adopted, followed and awarded WPI and apportionment for different parts of body from different evaluating physicians. But note the WCJ explained at length why he found different parts of the medical opinions from difference physician to be persuasive and either constitute or not constitute "substantial evidence".

See also, New Axia Holdings v. WCAB (Martinez) 79 CCC 196 (W/D) which held that it was it is the defendant who has the burden of establishing "overlap" under LC 4664, and not the applicant who has the burden of establishing that the prior disability no longer exists citing Kopping 71 CCC 1229.

See also, Gomez v. County of Los Angeles 2014 Cal.Wrk.Comp.P.D. LEXIS 119 (BPD) holding that apportionment under either 4663/4664 is applied to the adjusted disability not WPI.

August 2003 low back discectomy), and 10% neck (non-industrial injury which appears to be the 2004 injury associated with a fusion in August 2008).

The VR expert for applicant opined that the applicant was 100% disabled but provided no opinion on whether this was due to the industrial injury, nonindustrial injury, or a combination of the two.

The WCAB in upholding the WCJ found apportionment applying a LC 4663 analysis holding that LC 4662 requires that the total disability must be entirely the direct cause of the subject industrial injury. However, the WCAB rejected the defendant's argument that apportionment under LC 4664 was appropriate to a C&R settlement with a co-defendant citing *Pasquotto v. Hayward Lumber 71 CCC 223,* but noting that *Pasquotto* does not preclude apportionment under LC 4663. Last, the WCAB upheld the WCJ's determination that defendant had failed to meet their burden of proof in establishing apportionment under *Benson 170 Cal.App.4th 1548* on the issue of apportionment as between successive industrial injuries. Therefore, the overall PD was determined to be apportioned 80% industrial and 20% nonindustrial.

IV. Cumulative Trauma Injury and Apportionment of Liability as Between Co-Defendants

A. Discussion with Examples

Apportionment of Liability as between co-defendants again applies the doctrine of "Substantial Evidence" but is a highbred of the elements of "strict legal apportionment" and "Date of CT Injury. Apportionment of liability starts with an analysis to determine the Date of CT injury. Here the focus in on "injurious exposure/activity" and the documented consequence. Here the physician is expected through review of medical records, deposition transcripts, and review of job descriptions, to allocate liability among co-defendant who are either sharing the period of CT or are responsible for successive CT industrial injuries. This analysis is factually dependent and requires the reporting physician to use in equal parts medical knowledge, factual/medical information, and common sense. The primary consideration by the evaluating physician should focus on the physical arduousness of the industrial activity, and/or the intensity of the exposure/stressor in addressing the allocation of liability for the subject injurious exposure/activity period or periods. It is the evaluating physician's analysis that is the most important component to apportionment of liability as between co-defendants.

The first step in the analysis is to determine the date of CT injury: (1) Injurious industrial exposure, (2) Disability and (3) applicant's knowledge or reason to know the existence of a cause and effect relationship.

The second step is: Did the last date of "injurious exposure" occur before or after the "Date of CT Injury". If the "injurious exposure" ended before than the "Date of CTinjury", than liability would be on the carrier on the risk during the year ending with the ending of the "injurious exposure/activity/stressor". If the injurious exposure continued beyond "Date of CT Injury" than liability as between co-defendants would be the year period ending upon "Date of CT Injury".

Four Examples:

(1) Applicant has worked as farm laborer for 20 years and ultimately is taken off work to treatment with disability due to severe degenerative changes to bilateral knees resulting from his activities as a farm laborer. Prior to going off work applicant has no prior disability, including loss time from work, job modification or physical limitations or restrictions. Answer: Liability rolls into 20 year of employment on pro-rata basis.

(2) Applicant has worked 20 years, 10 years as a farm laborer, and 10 years in the farm office answering the phone. All evidence indicates the position answering phone was not injurious. Applicant is taken off work at end of 20 years of work for back surgery with no history of no prior disability, including loss time from work, job modification or physical limitations or restrictions. Answer: Liability rolls into 10 year of employment.

(3) Applicant has worked for 19 years, 10 years as a farm laborer, and is taken off work for 1 year for resulting back surgery, before returning to another 9 years as a farm laborer. At end of 20 year period applicant undergoes low back surgery. Alternatively, assume surgery at 10th year. Answer: Western Growers v. Successive CT?

(4) Applicant has worked for 20 years as a farm laborer. During the last year he worked 6 months as the farm labor supervisor which reduce significantly the physical arduousness of his work. At the conclusion of the 20th year he is taken off work for low back surgery without prior history of disability, including loss time from work, job modification or physical limitations or restrictions. Answer: Liability rolls into last year but allocation may not be pro-rata basis?

(5) Applicant is a sheriff overseeing and eleven officer department. During a two year period preceding a heart attack he is involved in litigation with one of his officer which he testifies is the only stressor related to his job. The litigation is resolved and the stressor ended 6 months before his heart attack. Answer: CT period and therefore liability end with ending of stressor/injurious exposure with liability on pro-rata basis.

B. Relevant Case Law

Western Growers Ins. Co. v. Wkrs.' Comp. App. Bd., (1993) 16 Cal.App.4th 227, 20 Cal. Rptr.2d 26

The applicant worked for over 20 years ultimately being promoted to superintendent in December 1984. The applicant began experiencing symptoms in 1985 when he was diagnosed with major depression. He was nervous, confused, could not make decisions, and suffered memory loss. On June 19, 1985, the applicant was first admitted to Kern View Community Mental Health Center and Hospital for evaluation and treatment and remained hospitalized from June 10 to July 26, 1985. Upon release, he returned to work as superintendent although he remained under doctor's care and on medication, and never fully recovered. The applicant's condition worsened and by March 1987, he could no longer perform the functions of his job and he obtained a work release from Dr. Shah. In 1988, Austin was again hospitalized for depression. His condition became permanent and stable on February 8, 1991.

Coverage was provided by Industrial during 1985 and Western during the period ending 1987.

The WCJ concluded that the applicant had sustained a cumulative trauma for the entire period of employment and awarded permanent disability against Western pursuant to Labor Code section 5500.5. The WCJ also awarded two periods of temporary disability. The first, the period of Austin's initial hospitalization in 1985, was charged to Industrial and the second, the period after March 1987, was charged to Western.

On reconsideration, the WCAB granted the petitions for the sole purpose of modifying the award, holding that the applicant had not been given notice of his right to benefits and thus defendant (Industrial) was estopped from raising a statute of limitations defense. In all other respects, the WCAB affirmed and adopted as its own the WCJ's findings and award.

On review, the Court of Appeal reversed holding that the WCAB's decision incorrectly applied section 5500.5 by holding the last carrier, Western, responsible for disability caused by one continuous, cumulative injury which first occurred during Industrial's period of coverage.

"Both the WCJ and the WCAB found Austin suffered from a single cumulative injury. This finding is supported by substantial evidence and binds this court on review. (LeVesque v. Workmen's Comp. App. Bd., supra, 1 Cal.3d at p. 637.) Dr. Wells opined even though Austin may have had a proclivity for depression prior to 1985, there was no evidence depression would have occurred absent the stress he suffered at work. Dr. Wells also reported that Austin never recovered from the depressive episode in 1985 and that he became progressively worse upon returning to work. It was the same stress that resulted in Austin's initial hospitalization in 1985 that further exacerbated the problem after he returned to work. Dr. Wells said the depressive episode that began in 1985 was never completely resolved. Austin remained under a doctor's care and on medication from 1985 onward. The WCAB's finding is also supported by Dr. Shah's discharge report and Austin's testimony. Austin may have improved for a short time after hospitalization, but he never recovered and his symptoms reappeared shortly after he returned to work, becoming progressively worse."

Western Growers Ins. Co. v. Wkrs.' Comp. App. Bd., (1993) 16 Cal.App.4th at pg. 235

"Section 3208.2 [antimerger doctrine] applies to the combination of injuries, not peri ods of disability. Under section 3208.1, an injury causing a need for medical treatment is compensable even in the absence of disability. In this case [the applicant] had a compensable injury from 1985 onward. Although he had two periods of disability, i.e., the inability to work, those two periods of disability were connected by a continuous need for medical treatment all caused by a single work-related cumulative injury, stress-induced depression. There was thus no time between 1985 and the present that Austin did not have a compensable injury.". . .

"As noted, the crucial date under section 5500.5 is either the date of injury as defined by section 5412, or the last date of exposure, whichever occurs first. In this case, the date of injury is June 1985. The last date of exposure was March 7, 1987. Thus, under the express language of section 5500.5, Industrial, who was the carrier in June 1985 and the immediately preceding year, bears full liability for the benefits owed Austin."

"Whatever application the provision relied upon may have in other factual situations, it does not nullify the express statutory language fixing liability for a single cumulative injury, as was found here, on those who employed the applicant during the earlier one-year period immediately preceding the date of injury. . .The WCAB's decision incorrectly applies section 5500.5 and for that reason must be annulled."

WESTERN GROWERS INS. CO. v. WKRS.' COMP. APP. BD., (1993) at pg. 16 Cal.App.4th at pgs. 236-238.

Editor's Comments: Western Growers may be explained by two simple comments: (1) The defendant on the initial period of exposure relied exclusively on establishing a single CT period through to the last date of employment/injurious exposure rather than considering that successive CT's may have occurred; and (2) No evidence was presented by Industrial (the first carrier) establishing that the second period upon applicant's return to work following applicant's 1985 hospitalization was a distinct injury involving a separate period of injurious exposure and resulting in a distinct period of temporary disability; and (3) Western (the second carrier) put on evidence that the first exposure ending 1985 constituted an industrial injury, that never resolved, and was responsible for an ongoing need for medical treatment, and a second period of TD, and resulting PD per the PTP and AME opinions. Simple put the evidence did not support a single ongoing CT period.

SCIF v. WCAB (Rodarte) 119 Cal.App. 4th 998, 69 Cal.Comp.Cases 579

> *See also, accord, City of Anaheim v. WCAB, 75 Cal.Comp.Cases 371; And Trini Rivera v. Fremont Comp et.al 2010 Cal.Wrk.Comp.P.D. LEXIS 56, holding prior Stipulations regarding date of injury may not be used to avoid carrier's right to contribution, rather a determination of either the date of injury, as determined pursuant to Section 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first.*
>
> *See also, Stanley v. Western Air & Refrigeration 46 Cal.Comp.Cases 197, 1981 Cal.Wrk.Comp. LEXIS 3093; Industrial Indemnity Company v. WCAB (National Steel) 145 Cal.App.3rd 480, 48 CCC 599; Scott Companu v. WCAB (Stanley) 139 Cal.App.3rd 98, 48 CCC 65, asbestosis/mesothelioma case holding the last year of "harmful exposure" which caused the occupational disease, not just exposure is required for the imposition of liability.*

Applicant claim a CT injury for the period ending 8/8/98 to right upper extremity resulting in carpal tunnel and tendinitis while employed as an assembler. The applicant's employment was continuous with one company, her employment was through two temporary placement agencies: Apple One 4/95-2/28/98 insured by a carrier in liquidation admistered by CIGA; Temptrak 3/1/98-8/7/98 insured by SCIF. On 10/3/97 Rodarte received medical treatment which included anti-inflammatory medicals, a wrist brace, and physical therapy, with the PTP permitting applicant to return to modified work. Rodarte filed a claim on 10/97. Rodarte continued to work without her managers knowledge of the injury. Althogh Rodarte's manager initially provided accomodations, Rodarte's was terminated upon finding out about the injury based upon the fact the applicant could not do her job duties. At hearing Rodarte testified she would have continued but for being terminated.

The AME found a continuous CT through 8/98 when Rodarte quit working. The WCJ found a single CT for the period ending with the applicants termination8/7/98, last year of work, which found SCIF liable for the entire claim.

On reconsideration the WCAB reversed holding (1) that the date of injury under section 5500.5 requires compensable temporary disability *or* permanent disability; (2) Modified work is insufficient to establish TD which requires actual wage loss (3) but modified work may indicate a *permanent* impairment of earning capacity for the establishment of PD under 5412 necessary to establish a CT injury; and (4) under LC 5500.5 provides that liability for occupational disease or cumulative injury claims shall be limited to those employers who employed the employee during the period of one year "[I]mmediately preceding either the date of injury, as determined pursuant to Section 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first."; and (5) medical treatment alone is not disability, but it may be evidence of compensable permanent disability, as may a need for splints and modified work. Remanded.

SCIF v. WCAB (Dorsett) (6th District Court of Appeal, 2011) 76 CCC 1138

> *". . .Employers must compensate injured workers only for that portion of their permanent disability attributable to a current industrial injury, not for that portion attributable to previous injuries or to nonindustrial factors. . .Apportionment is now based on causation. . .the new approach to apportionment is to look at the current disability and parcel out its causative sources – nonindustrial, prior industrial, current industrial – and decide the amount directly caused by the current industrial source. . . Therefore, evaluating physicians, WCJ and WCAB must make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of the [industrial injury]. . .and caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. . .*
>
> *There may be limited circumstances. . . when the evaluating physician cannot parcel out, with reasonable medical probability, the approximate percentage to which each distinct industrial injury causally contributed to the employee's overall permanent disability. In such limited circumstances, when the employer has failed to meet its burden of proof, a combined award may still be justified. . .the burden of proof falls on the employer for it is the employer who benefits from apportionment.*
>
> *SCIF v. WCAB (Dorsett) 76 CCC at pg. 1144.*

Applicant sustained a specific injury to cervical spine on 3/21/00 while working for South Valley Glass and a CT injury to cervical spine for the period ending 6/8/04 while working for A-Tek. Both were insured by SCIF. The AME wrote that in the absence of the specific injury in 2000, the subsequent activities with the second employer would not have been injurious and therefore the subsequent CT would not have occurred. At deposition the AME testified "if the initial [injury] doesn't happen. . .the second [injury] can't happen because there's no indication medically that he would have had any disability in 2004 absent the first injury of 2000." Even so, the AME apportioned the disability equally as between the two injuries. Based upon the opinion of the AME, the WCJ made a 100% award, refusing to apportion, finding only a single injury in that the second injury was a compensable

consequence of the original injury. Defendant sought reconsideration and after denial, a Writ of Review.

The Court of Appeal discussed at length whether a subsequent injurious industrial activity can be a compensable consequence of a prior injury for the purpose of avoiding apportionment under LC 4663. In the end, the Court reversed holding that separate injuries had occurred and since the AME had been able to apportion as between these injuries the WCJ was compelled to find apportionment. The Court also seemed to stress that it would be a rare situation where apportionment would not exist were successive injuries are involved.

See also, Pruitt v. California Department of Corrections, SCIF 2011 Cal. Wrk. Comp, P.D. Lexis 553(Panel Decision) (involving inmate firefighter jumping 6 feet down to escape fire) in which the decision of WJC finding no apportionment was reversed where based upon the opinion of the PTP who noted "in this case, there is nothing in the medical records that shows that the patient had any problem with her bilateral knees prior to her industrial injury. . .[or that] absent her industrial injury [the applicant would have any disability] . . . Therefore, apportionment to pre-existing or other factors is not warranted." The WCAB in reversing found that the medical opinion relied upon was premised on an incorrect legal theory and did not, therefore, constitute substantial medical evidence.

But see contra, Bridgestone Firestone v. WCAB Fussell (2011) 76 CCC 1326 (Writ Denied) in which the finding of no apportionment to pre-existing diabetes which was under control was upheld. See also, contra, Cal. Indemnity Insurance Co. v. WCAB (Whiteley) 76 CCC 1332 (Writ Denied) in which no apportionment to CT, where substantial medical evidence attributed all of applicant's symptoms and impairment to specific injury only.

Editor's Comments: It should be noted that the Dorsett decision is also valuable on the issue of whether the defendant on a subsequent injury may avoid liability arguing that the second injury is merely a compensable consequence of the original injury (prior) industrial injury. Traditionally, the principle of "compensable consequence" has been limited to non-industrial conditions or activities which result in an increase in the need for medical treatment, to extend periods of TD or an increased in PD. Where the subsequent injurious activity is industrial, a second industrial injury has occurred. The rationale for this is that (1) the an employer takes the employee as he find him, and (2) will be held responsible for that portion of PD which is directly and causally related to an injurious industrial activity or exposure, despite the fact that a prior injury may make the applicant/employee more susceptible to injury.

24 Cal. Comp. Cases 274

Copy Citation

Reporter

24 Cal. Comp. Cases 274 * 1959 Cal. Wrk. Comp. LEXIS 182 ** 175 Cal. App. 2d 592 *** 346 P.2d 545 ****

ROBERT H. BEVERIDGE, Petitioner, v. INDUSTRIAL ACCIDENT COMMISSION et al., Respondents

Subsequent History:

[**1] The Petitions of Respondents Industrial Accident Commission and Columbia Casualty Co. for a Hearing by the Supreme Court were Denied January 20, 1960. Spence, J., and McComb, J., were of the Opinion that the Petitions Should be Granted.

Prior History:

PROCEEDING to review an order of the Industrial Accident Commission that evidence failed to establish that petitioner suffered an industrial injury on or before a certain date.

Disposition: Order annulled with directions.

Core Terms

disable, preexisting, strain, aggravate, exposure, disease, statute of limitations, work effort, cumulative effect

Counsel

Watson A. Garoni for Petitioner.

Everett A. Corten, Emily B. Johnson and R. P. Wisecarver for Respondents.

Opinion By: TOBRINER

Opinion

[*275] [***593] [****546] The petitioner seeks review and annulment of the findings and order of the respondent Industrial Accident Commission that the evidence failed to establish that he suffered an industrial injury on or about October 20, 1958, and that he take nothing by reason of his claim.

The issue which emerges is whether the statute of limitations for a claim for workmen's compensation (1) runs from the date of final stoppage of work if the accumulated strain of work effort causes a preexisting condition to become disabling on such date or (2) runs, in the absence of a new traumatic incident, from the date of the original [**2] injury causing the preexisting condition. A subsidiary question involves respondent's defense that since petitioner at the hearing advanced the theory that he sustained a new traumatic injury on October 20, 1958, he cannot now contend that disability results from aggravation of the preexisting condition. We consider these problems hereafter.

The factual background of these issues involves the preexisting back condition and the episode of October 20, 1958.

While the petitioner, a 39-year-old electrician, alleged in his application that on October 20, 1958, he sustained an injury to his back which aggravated a preexisting low back disability, he testified to a prior injury to his back which occurred in 1953. The 1953 injury necessitated three weeks of hospitalization and an additional three weeks of recuperation. Since then, he testified, he has had recurrent episodes of pain in his low back and left leg. Again in February 1956 he suffered further back injury which required two weeks of diathermic treatment. Thereafter he continued to take self-conducted heat treatments at home.

The episode of October 20, 1958, occurred when he lifted a 70-pound coil of electrical conduit and felt [**3] a "twinge" of pain in his back. Although applicant testified that he believed he

coincidentally told one of his supervisors of this injury, his employer testified that he did not remember receiving this information. Because of unavailability the other supervisor did not testify. Applicant continued to work until [****547] December 17, 1958. Thereafter he became totally disabled because of his back condition.

Although applicant requested medical care of respondent, the carrier denied compensation benefits upon the ground that his difficulty resulted solely from the 1953 injury. Resorting to self-procured medical care, applicant obtained the services of Doctor John J. Demas, an orthopedist. Although on January [***594] 6, 1959, a laminectomy was performed, applicant's back remained in a severe condition and, according to his doctor, future treatment and observation will be necessary.

Doctor Demas' medical report made up the sole medical statement placed in evidence. The report in part states: "this patient has had, since 1953, a preexisting disability. **[*276]** *His subsequent work to that time has acted as an aggravation of this disability, and the patient's present condition is the* [**4] *effect of such aggravation.* This patient has never been asymptomatic since 1953, by the history given to us." (Emphasis added.) At the hearing, Dr. Demas testified in answer to a question whether the "disease" had progressed to the point where he operated, "I am not certain I know what you mean by the term 'disease' here, because certainly this man's condition has deteriorated in the five years." Asked whether this isn't "called a discogenic disease" the physician answered, "Well, yes, if you want to put it that way. It has deteriorated."

The referee issued his findings and order holding that the applicant did not sustain an injury arising out of and occuring in the course of employment and was not entitled to compensation benefits. The commission denied a petition for reconsideration, and applicant then brought this petition for writ of review.

The contentions of the parties turn on the question as to the date from which the statute of limitations runs. Respondents contend that, since the original injury occurred in 1953, applicant's claim is "barred by the statute of limitations." Petitioner argues that if the injury results from the cumulative effects of the employment the [**5] statute runs from the date upon which the employee's condition compels him to stop working. In such case, the claim would not be barred, since applicant stopped working on December 17, 1958. The relevant Labor Code, section 5411, provides: "The date of injury, except in cases of occupational disease, is that date during the employment on which occurred the alleged incident or exposure, for the consequences of which compensation is claimed."

While it is true that the power of an appellate court is confined to a determination as to whether substantial evidence supports the commission's determinations of fact (*Douglas Aircraft, Inc.* v. *Industrial Acc. Com.* (1957), 47 Cal.2d 903, 905 [306 P.2d 425]), we find here, as we shall point out, that the commission applied an unsupportable theory to the ascertained facts and that the facts contradict its conclusions.

We think the proposition irrefutable that while a [***595] succession of slight injuries in the course of employment may not in themselves be disabling, their cumulative effect in work effort may become a destructive force. The fact that a single but slight work strain may not [**6] be disabling does not destroy its causative effect, if in combination with other such strains, it produces a subsequent disability. The single strand, entwined with others, makes up the rope of causation.

The fragmentation of injury, the splintering of symptoms into small pieces, the atomization of pain into minor twinges, the piecemeal contribution of work-effort to final collapse, does not negate injury. The injury is still there, even if manifested in disintegrated rather than in total, single impact. In reality the only moment when such injury can be visualized as taking compensative form is the date of last exposure, when the cumulative effect causes disability.

This principle finds expression in 2 Hanna, The Law of Employee Injuries and [****548] Workmen's Compensation: "Injury may result from the accumulated effects of overwork or from long-continued exposure to tension and strain. Where there is such an extended exposure, the result is regarded as one continuous, cumulative injury rather than as a **[*277]** series of individual injuries. Separately, each day's strain may be slight, but when added to the strains which have preceded, it becomes a destructive force. With such an injury, [**7] the statute of limitations runs from the date of the last exposure." (Pp. 133–134.)

The Supreme Court has applied the principle to a case in which an employee, exposed to 65 days of tension in labor negotiations, sustained an aggravation of "an existing hypertension which in turn . . . [precipitated] a cerebral vascular accident." (*Fireman's Fund Indem. Co.* v. *Industrial Acc. Com.*, 39 Cal.2d 831, 832 [250 P.2d 148].) The court points out that in the development of this condition, a point exists, "where without further strain and tension resulting from the employment, the stroke will result." The court states, "This point is reached through the cumulative effect of each day's strain and tension. Separately one day's strain may be slight, but when added to the strains which have preceded, it becomes a destructive force. . . . Therefore, it must be concluded that the stroke here was the result of one continuous cumulative injury rather than a series of individual injuries." (P. 834.) The analogy to successive work-incurred back injuries is strong, despite the difference in physical disabilities.

The court expresses its underlying [**8] reason for fixing the date [***596] from which the statute runs as that after the exposures "have been concluded": "To require the employee to file his claim within a limited time from the first exposure would be unreasonable. After a single exposure the employee might be totally unable to notice that a deleterious effect has taken place. Only after extended exposure may the effects become noticeable. Consequently, it should only be after the exposures constituting the continuous injury have been concluded that the period of the statute of limitations commences to run." (P. 834.) We believe this reasoning entirely applicable to the instant case.

The same approach becomes manifest in *Limited M. C. Ins. Co.* v. *Industrial Acc. Com.* (1940), 37 Cal.App.2d 50 [98 P.2d 837]. In that case a linoleum mechanic suffered from a preexisting *nondisabling knee difficulty but the commission found the disabling injury occurred on a subsequent* date. The existence of the preexisting general condition did not obviate the accumulative impact of that condition into a disabling injury upon a specific date. The court says, "The mere existence of the [**9] preexisting non-disabling condition, which was admitted, does not necessarily preclude the commission from finding that the disabling injury occurred on a specific date, and awarding compensation based on that injury. Industry takes the employee as he is at the time of his employment. For subsequent injuries lighting up or aggravating that condition, rendering it disabling, he is entitled to compensation. [Citations.]" (P. 55.)

The commission itself has taken this position. In *Fidelity & Casualty Co. of New York* v. *I.A.C.* (1944), 9 C.C.C. 294, the commission held that an employee sustained injury to her back in January, 1943, although she began suffering such back discomfort in 1942 and quit working in 1943 because of that condition. She worked thereafter, but the doctor reporting on her behalf stated "'numerous sprains of the back were suffered . . . Each sprain was at first minor . . . until the frequently repeated lifting with a back gradually rendered more and more vulnerable became so much of an injury and caused so much pain she had to quit.'" (Pp. 294–295.) In this case, "It was the position of the Commission that the strains of the [**10] employment, operating upon a vulnerable **[*278]** [****549] back, *produced a disabling condition which constituted an injury, and that the statute of limitations began* to run *from the time her condition compelled her to quit work*, which was well within six months of the date when the application was filed." [***597] (P. 295; emphasis added.) To the same effect: *Liberty Mutual Ins. Co.* v. *I.A.C.* (1956), 21 C.C.C. 117; *Lumbermen's Mut. Cas. Co.* v. *Industrial Acc. Com.* (1946), 29 Cal.2d 494 [175 P.2d 823].

Yet the referee here proceeded upon the premise that, with the exception of the occupational disease cases, in order to produce "an aggravation that could cause a latent or pre-existing condition, not disabling to become disabling there must have been a *new incident*. . . ." (Report of Referee on Reconsideration, p. 3; emphasis added.) The cumulative effect of work effort aggravating the prior condition, however, which reaches its climax in disability, is the equivalent for the "new incident," the "accident," the "new injury" which the referee claims did not occur here. The synthesis of symptoms and [**11] effort is as much causative of disability as a new trauma; a distinction between them would be verbal, not real.

The referee, likewise, failed to evaluate the relationship of applicant's work effort to his back condition. The referee implies that the original injury worsened merely through the process of time and life itself. He analogized it to a common cold which culminates in pneumonia: a progression that might have no connection with employment. Yet, this applicant performed heavy manual work, and his doctor states that the nature of his work led to the final rupture of the back. The commission could not properly ignore this uncontradicted evidence (*William Simpson Const. Co.* v. *Industrial Acc.*

Com. (1925), 74 Cal.App. 239, 243 [240 P. 58]; *Nielsen* v. *Industrial Acc. Com.* (1932) 125 Cal.App. 210 [13 P.2d 517]) and substitute for it *a priori* observations. In any event the referee states that, "Maybe *his work* played some part in it [the aggravation of applicant's condition]" and "that the mere exigencies of living played as much part *as his work activity may have* [**12] ." (Report of Referee on Reconsideration, pp. 3, 6; emphasis added.) If the work effort did contribute to the rupture, that causation cannot be ignored, and the award pinioned entirely upon nonindustrial factors.

Even upon the referee's theory that applicant suffered from a "discogenic disease," the referee could not entirely discount the physician's testimony that the work effort aggravated this condition into disabling symptoms. The cases hold that "A disease which, under any *rational work*, is likely to progress so as finally to disable the employee, does not become a 'personal injury' under the act merely because it reaches the point of disablement while work for a subscriber is being [***598] pursued. It is only when there is a direct causal connection between the exertion of the employment and the injury that an award of compensation can be made. *The substantial question is whether the diseased condition was the cause, or whether the employment was a proximate contributing cause.* In the former case, no award can be made; in the latter, it ought to be made." (*California etc. Exchange* v. *Industrial Acc. Com.* (1946), 76 Cal.App.2d 836, 842 [174 P.2d 680]; [**13] emphasis added.) The referee, we believe, failed to consider the relationship of the "rational" work of the applicant, in the light of the doctor's report, and the effect of such work effort in precipitating the final collapse of the preexisting back condition.

[*279] We conclude that since the accumulated strain of work effort caused applicant's preexisting back condition to become disabling on December 17, 1958, the claim is not barred by the statute of limitations.

We turn to the subsidiary point that petitioner has foreclosed himself from benefits based upon the above theory because his application reads that he sustained injury on or about October 20, 1958, [****550] and because he allegedly contended at the hearing that this was the date of his injury. In the first place, applicant answers that he inserted that date as the "date of injury" because it was then that the final culmination of the preexisting condition caused total inability to work. In the second place and more basically, we do not believe that awkwardness in allegation should constrict a worker's right to compensation. In many cases before the Industrial Accident Commission, applicants are not represented by [**14] and lack advice as to procedural niceties. The applicant's claim is entitled to adjudication upon substance rather than upon formality of statement.

The findings and order denying petition for reconsideration of the Industrial Accident Commission are annulled, vacated and set aside. The case is remanded to that commission for proceedings in accordance with this decision.

Content Type: Administrative Materials

Terms: 24 Cal Comp Cases 274

Western Growers Ins. Co. v. Workers' Comp. Appeals Bd., 16 Cal. App. 4th 227

Copy Citation

Reporter

16 Cal. App. 4th 227 * 20 Cal. Rptr. 2d 26 ** 1993 Cal. App. LEXIS 575 ***

WESTERN GROWERS INSURANCE COMPANY, Petitioner, v. WORKERS' COMPENSATION APPEALS BOARD, BOYD WAYNE AUSTIN et al., Respondents.

Subsequent History: [***1] Review Denied August 19, 1993, Reported at: 1993 Cal. LEXIS 4440.

Prior History: ORIGINAL PROCEEDING; petition for writ of review. WCAB Nos. 87 BAK 38776 & BAK 104158

Disposition: The WCAB's decision after reconsideration is annulled, and the matter is remanded for further proceedings consistent with this opinion.

Core Terms

disability, cumulative injury, depression, Industrial, benefits, injuries, workers' compensation, occupational disease, permanent, coverage, carrier, medical treatment, apportionment, temporary disability, hospitalization, merged, period of disability, compensable injury, date of injury, compensated, continuous, cumulative, exposure, cases, question of fact, return to work, temporary, insured, disability benefits, specific injury

Case Summary

Procedural Posture

Appellant insurance carrier challenged a decision from respondent Workers' Compensation Appeals Board (California), which affirmed a judgment that awarded permanent disability to appellee employee against appellant pursuant to Cal. Lab. Code § 5500.5. Respondent board also awarded respondent employee two periods of temporary disability and appellant was charged with one temporary disability while another carrier was charged with the other.

Overview

Respondent employee filed several claims for workers' compensation benefits. He worked for the same company for nearly 25 years until he became disabled due to recurrent depression. During the term of employment, appellant insurance carrier and another carrier provided workers' compensation coverage to employer at different intervals. Respondent workers' compensation appeals board (board) awarded respondent employee permanent disability against appellant and also awarded two periods of temporary disability, one of which appellant was charged with. Upon review, the court annulled the award. The court held that liability for respondent employee's disability was improperly imposed on appellant because the disability was caused by one continuous cumulative injury that first occurred during another insurance carrier's period of coverage. The court reasoned under Cal. Gov't Code § 5500.5, liability of the entire injury was to be imposed upon the carrier who provided coverage during the year immediately preceding the date of the injury or the date of last exposure. The court found that the date of the cumulative injury began when respondent employee was first hospitalized for depression.

Outcome

The court annulled the decision that found appellant insurance carrier was liable for workers'

compensation benefits for respondent employee's disability of recurrent major depression. The court held that appellant was not responsible for respondent employee's disability because the disability was caused by one cumulative injury that occurred during another carrier's coverage *period*.

▼ LexisNexis® Headnotes

Administrative Law > Judicial Review > Standards of Review > General Overview

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review > General Overview

HN1 **Judicial Review, Standards of Review**
In considering a petition for writ of review of a decision of the Workers' Compensation Appeals Board (WCAB), the appellate court's authority is limited. The appellate court must determine whether the evidence, when viewed in light of the entire record, supports the award of the WCAB. The appellate court may not reweigh the evidence or decide disputed questions of fact. However, the appellate court is not bound to accept the WCAB's factual findings if determined to be unreasonable, illogical, improbable or inequitable when viewed in light of the overall statutory scheme. Questions of statutory interpretation are, of course, for the appellate court to decide.
More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Compensability > Injuries > Accidental Injuries

Workers' Compensation & SSDI > Administrative Proceedings > Awards > Types of Awards

Workers' Compensation & SSDI > Benefit Determinations > Earning Capacity

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > General Overview

Workers' Compensation & SSDI > Compensability > Injuries > General Overview

Workers' Compensation & SSDI > Compensability > Injuries > Cumulative Injuries

HN2 **Injuries, Accidental Injuries**
Under the workers' compensation statute, there are two distinct types of industrial "injuries." A compensable injury can be either "specific" or "cumulative." Cal. Lab. Code § 3208.1. A cumulative injury is one which results from repetitive events, occurring during each day's work, which in combination cause any disability or need for medical treatment. A worker suffering from a cumulative injury may invoke the rights and benefits provided under California's workers' compensation laws when the cumulative effects of the repetitive events result in a compensable injury, i.e., one resulting in lost wages or the need for medical treatment. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Compensability > Injuries > Cumulative Injuries

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review >

General Overview

HN3 **Injuries, Cumulative Injuries**
In any given situation, there can be more than one injury, either specific or cumulative or a combination of both, arising from the same event or from separate events. The number and nature of the injuries suffered are questions of fact for the Workers' Compensation Judge or the Workers' Compensation Appeals Board. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Compensability > Injuries > Cumulative Injuries

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review >

General Overview

Workers' Compensation & SSDI > Compensability > Injuries > General Overview

Workers' Compensation & SSDI > Compensability > Injuries > Psychological Injuries

HN4 **Injuries, Cumulative Injuries**
One exposure may result in two distinct injuries, posing a question of fact. More like this Headnote

Shepardize - Narrow by this Headnote

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Compensability

> Occupational Diseases

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Temporary Total Disabilities

HN5 **Workers' Compensation, Occupational Diseases**
The workers' compensation statute provides indemnity for both temporary and permanent disabilities. A temporary disability is impairment reasonably expected to be cured or materially improved with proper medical care. A disability, other than one resulting from a progressive occupational disease, is permanent when the employee's condition has reached maximum improvement or the condition has become stationary for a reasonable period of time. A disability cannot be both permanent and temporary at the same time. When a disability changes from temporary to permanent, the permanent disability is considered a new and further disability. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Temporary Total Disabilities

HN6 **Benefit Determinations, Permanent Partial Disabilities**
Temporary disability benefits are intended primarily to replace lost earnings. Permanent disability benefits are to compensate both for actual incapacity to work and for the physical impairment suffered. When there are two discrete periods of temporary disability, they are not merged into a single disability but are treated as separate entitlements to benefits. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Administrative Proceedings > Evidence >

General Overview

HN7 **Administrative Proceedings, Evidence**
See Cal. Labor Code § 3208.2. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations >

Cumulative & Successive Disabilities

HN8 **Benefit Determinations, Cumulative & Successive Disabilities**
Cal. Lab. Code § 3208.2 applies to the combination of injuries, not periods of disability. More like this Headnote

Shepardize - Narrow by this Headnote

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Compensability > Occupational Diseases

Workers' Compensation & SSDI > Compensability > Injuries > Cumulative Injuries

Workers' Compensation & SSDI > Administrative Proceedings > General Overview

Workers' Compensation & SSDI > Administrative Proceedings > Claims > General Overview

Workers' Compensation & SSDI > Administrative Proceedings > Claims > Filing Requirements

Workers' Compensation & SSDI > ... > Claims > Statute of Limitations > General Overview

Workers' Compensation & SSDI > ... > Claims > Statute of Limitations > Claims Periods

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

HN9 **Workers' Compensation, Occupational Diseases**
See Cal. Lab. Code § 5500.5. More like this Headnote

Shepardize - Narrow by this Headnote

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Compensability > Occupational Diseases

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Compensability > Injuries > Cumulative Injuries

HN10 **Workers' Compensation, Occupational Diseases**
See Cal. Lab. Code § 5412. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations ▾ >

Cumulative & Successive Disabilities ▾

HN11 **Benefit Determinations, Cumulative & Successive Disabilities**
Where there is but one continuous cumulative injury, Cal. Lab. Code § 5500.5 provides that liability for the entire injury is imposed upon the carrier who provided coverage during the year immediately preceding the date of injury or the date of last exposure, whichever occurs first. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Coverage ▾ > Actions Against Employers ▾ >

Statutory Requirements for Adequate Coverage ▾

HN12 **Actions Against Employers, Statutory Requirements for Adequate Coverage**
Liability is a legal question determined with reference to the statutory scheme, not a medical question. More like this Headnote

Shepardize - Narrow by this Headnote

▼ Headnotes/Syllabus

Summary

CALIFORNIA OFFICIAL REPORTS SUMMARY

An employee suffered from major recurrent depression and filed several claims for workers' compensation benefits. Two insurers were the workers' compensation carriers for the relevant periods. The workers' compensation judge (WCJ) concluded that the employee had sustained a cumulative trauma for the entire period of employment and awarded permanent disability against the first carrier pursuant to Lab. Code, § 5500.5. The WCJ also awarded two periods of temporary disability. The first period was charged to the second carrier, and the second period was charged to the first carrier. After the Workers' Compensation Appeals Board (WCAB) affirmed and adopted the WCJ's findings and award with one modification, the first carrier petitioned the Court of Appeal for a writ of review.

The Court of Appeal annulled the decision of the WCAB and remanded for further proceedings. It held that substantial evidence supported the finding that the employee had suffered a single compensable injury. It also held that the WCJ did not impermissibly merge two periods of continuous trauma in violation of Lab. Code, § 3208.2. However, it held that in assessing liability, the WCJ incorrectly applied Lab. Code, § 5500.5 (apportioning liability for cumulative injury). Since the WCJ found that there was but one continuous cumulative injury, under the terms of Lab. Code, 5500.5, the second carrier, who was the carrier during the time of, and the one-year period immediately preceding, the injury, bore full responsibility for the benefits. (Opinion by Thaxter ▾, J., with Martin ▾, Acting P. J., and Vartabedian ▾, J., concurring.)

Headnotes

CALIFORNIA OFFICIAL REPORTS HEADNOTES

Classified to California Digest of Official Reports

CA(1) **(1) Workers' Compensation § 127—Judicial Review—Scope.**

--In considering a petition for a writ of review of a decision of the Workers' Compensation Appeals Board (WCAB), the appellate court's authority is limited. It must determine whether the evidence, when viewed in light of the entire record, supports the award of the WCAB. The court may not reweigh the evidence or decide disputed questions of fact. However, the court is not bound to accept the WCAB's factual findings if determined to be unreasonable, illogical, improbable, or inequitable when viewed in light of the overall statutory scheme. Questions of statutory interpretation are for the court to decide.

CA(2) **(2) Workers' Compensation § 45—Compensable Injuries—Cumulative Injury: Words, Phrases, and Maxims—Cumulative Injury.**

--Under the workers' compensation statutes, there are two distinct types of industrial injuries. Pursuant to Lab. Code, § 3208.1, a compensable injury can be either "specific" or "cumulative." A cumulative injury is one that results from repetitive events, occurring during each day's work, which in combination cause any disability or need for medical treatment. A worker suffering from a cumulative injury may invoke the rights and benefits provided under the workers' compensation laws when the cumulative effects of the repetitive events result in a compensable injury, i.e., one resulting in lost wages or the need for medical treatment. In any given situation, there can be more than one injury, either specific or cumulative or a combination of both, arising from the same event or from separate events. The number and nature of the injuries suffered are questions of fact for the workers' compensation judge. In addition, one exposure may result in two distinct injuries, posing another question of fact. The nature and the number of injuries suffered are determined by the events leading to the injury, the medical history of the claimant, and the medical testimony received.

CA(3) **(3) Workers' Compensation § 130—Judicial Review—Substantial Evidence—Finding That Employee Suffered Single Cumulative Injury—Employee Suffering From Recurrent Depression.**

--Substantial evidence supported the finding of a workers' compensation judge and the Workers' Compensation Appeals Board that an employee, who suffered recurrent major depression, suffered a single compensable injury. Thus, on review, the Court of Appeal was bound by the finding. A physician opined that even though the employee may have had a proclivity for depression prior to his hospitalization in 1985, there was no evidence depression would have occurred absent the stress he suffered at work. The physician also reported that the employee never recovered from the first depressive episode and that he became progressively worse upon returning to work. The depressive episode that began in 1985 was never completely resolved,

and the employee remained under a doctor's care and on medication. Also, another physician's discharge report indicated that the employee may have improved for a short time after hospitalization, but he never recovered and his symptoms reappeared shortly after he returned to work, becoming progressively worse.

CA(4a) **(4a)** *CA(4b)* **(4b)** *CA(4c)* **(4c) Workers' Compensation § 106—Benefits Recoverable to Employee—Permanent Disability—Impermissible Merger of Multiple Disabilities—Continuous Trauma.**

--In determining an employee, who suffered recurrent major depression resulting in two periods in which he could not work, suffered a single compensable injury, the workers' compensation judge did not impermissibly merge two periods of continuous trauma in violation of Lab. Code, § 3208.2 (multiple injuries having combined effects). Lab. Code, § 3208.2, applies to the combination of injuries, not periods of disability. Under Lab. Code, § 3208.1 (specific and cumulative injuries), an injury causing a need for medical treatment is compensable even in the absence of disability. The employee had a compensable injury from 1985 onward. Although he had two periods of disability, i.e., the inability to work, those two periods of disability were connected by a continuous need for medical treatment all caused by a single work-related cumulative injury, stress-induced depression. There was thus no time between 1985 and the present that the employee did not have a compensable injury. The two periods of disability were not distinct.

[See 2 **Witkin,** Summary of Cal. Law (9th ed. 1987) Workers' Compensation, § 281.]

CA(5) **(5) Workers' Compensation § 104—Benefits Recoverable to Employee—Temporary and Permanent Disability: Words, Phrases, and Maxims—Temporary Disability—Permanent Disability.**

--Workers' compensation law provides indemnity for both temporary and permanent disabilities. A temporary disability is impairment reasonably expected to be cured or materially improved with proper medical care. A disability, other than one resulting from a progressive occupational disease, is permanent when the employee's condition has reached maximum improvement or the condition has become stationary for a reasonable period of time. A disability cannot be both permanent and temporary at the same time. When a disability changes from temporary to permanent, the permanent disability is considered a new and further disability. Temporary disability benefits are intended primarily to replace lost earnings. Permanent disability benefits are to compensate both for actual incapacity to work and for the physical impairment suffered. When there are two discrete periods of temporary disability, they are not merged into a single disability but are treated as separate entitlements to benefits. Whether a disability is permanent or temporary is a question of fact.

CA(6) **(6) Workers' Compensation § 45—Compensable Injuries—Statute Defining Specific and Cumulative Injury—Legislative Intent.**

--The legislative intent of Lab. Code, § 3208.2, which governs the determination of fact and law

where multiple injuries have combined effects, was to nullify court decisions allowing the merger of past specific injuries into a cumulative injury. The court cases giving rise to the antimerger statute address, for the most part, past specific injuries to a worker which were merged into a later cumulative injury thus allowing recovery of benefits otherwise barred by the statute of limitations. The specific injuries were usually separated by periods when no compensable injury existed. When these injuries were merged into a later cumulative injury, insurance carriers who had already compensated the worker for the benefits due for the specific injuries were charged with a share of the disability benefits later due as a result of the cumulative injury. Merging defeated the purposes of the statute of limitations and left insurance carriers and employers open to risk for lengthy periods of time.

CA(7a) **(7a)** *CA(7b)* **(7b) Workers' Compensation § 41—Person Against Whom Compensation May Be Awarded—Insurance Carriers—Apportioning Award Among Multiple Carriers—Single Continuous Trauma Resulting in Two Periods of Disability.**

--In assessing liability for a workers' compensation award to the first of two insurance carriers, the workers' compensation judge (WCJ) incorrectly applied Lab. Code, § 5500.5 (apportioning liability for cumulative injury). The employee suffered from major recurrent depression and suffered two periods of disability, and the two insurers were the carriers for the relevant periods. The WCJ concluded that the employee had sustained a cumulative trauma for the entire period of employment and awarded permanent disability against the first carrier, who was the carrier during the second disability period. The date of a cumulative injury is the date an employee first suffers a disability (Lab. Code, § 5412). Since the WCJ found that there was but one continuous cumulative injury, under the terms of Lab. Code, 5500.5, the second carrier, who was the carrier during the time of, and the one-year period immediately preceding the injury, bore full responsibility for the benefits.

CA(8) **(8) Statutes § 46—Construction—Presumptions—Legislative Intent.**

--When enacting statutes, the Legislature is presumed to have meant what it said, and the plain meaning of the language governs. When the words are clear, there is no room for interpretation.

CA(9) **(9) Workers' Compensation § 74—Proceedings Before Workers' Compensation Appeals Board—Evidence—Report of Agreed Medical Examiner.**

--In determining that an employee's multiple disabilities were the result of a single injury (depression), the Workers' Compensation Appeals Board (WCAB) did not err in failing to give greater deference to the report of an agreed medical examiner that apportioned some of the disability to the employee's previous proclivity to depression. The workers' compensation judge (WCJ) considered the report carefully and in her recommendation to the WCAB on the petition for reconsideration, she noted that there was an inconsistency between the doctor's conclusion that no depression would have developed in the absence of the work experience and his apportionment to a "pre-existing pattern of recurrent depression." In her award and in her report and recommendation on the petition for reconsideration, the WCJ stated clearly she rejected the claim that the employee's depression may have been caused in part by family problems. Liability is a legal question determined with reference to the statutory scheme

governing workers compensation, not a medical question.

Counsel: Dressler & Quesenbery ▾ and Michael R. Wadsworth ▾ for Petitioner.

Mullen & Filippi ▾, Bruce K. Wade ▾ and Joseph Pluta ▾ for Respondents.

Judges: Opinion by Thaxter ▾, J., with Martin ▾, Acting P. J., and Vartabedian ▾, J., concurring.

Opinion by: THAXTER ▾, J.

Opinion

[*231] [**29] Respondent Boyd Wayne Austin was employed by respondent Kirschenman Enterprises for approximately 25 years until March 17, 1987, when he became disabled. Austin suffered from major recurrent depression. Petitioner Western Growers Insurance Company (Western) and respondent Industrial Indemnity (Industrial) were the workers' compensation carriers for Kirschenman Enterprises during the relevant periods. After leaving his employment, Austin filed several claims for workers' compensation benefits (case Nos. 87 BAK 38774, 87 BAK 38775, 87 BAK 38776, **[*232]** BAK 104158). The cases were consolidated for consideration and heard [***2] by the workers' compensation judge (WCJ).

On May 1, 1992, the WCJ issued her findings and award in all four cases. The WCJ concluded in case Nos. 38776 and 104158 that Austin had sustained a cumulative trauma for the entire period of employment and awarded permanent disability against Western pursuant to Labor Code section 5500.5. [1] The WCJ also awarded two periods of temporary disability. The first, the period of Austin's initial hospitalization in 1985, was charged to Industrial and the second, the period after March 1987, was charged to Western. In case Nos. 38774 and 38775 Austin received no award.

Western filed with the Workers' Compensation Appeals Board (WCAB) a petition for reconsideration pursuant to section 5900. Industrial also filed a petition for reconsideration. After consideration of the record and the WCJ's report, the WCAB granted the petitions for the sole purpose of modifying the award to add an 11th finding of [***3] fact that Industrial had failed to prove that Austin had been given notice of his right to benefits and thus was estopped from raising a statute of limitations defense. In all other respects, the WCAB affirmed and adopted as its own the WCJ's findings and award.

We granted Western's petition for writ of review. In this court, Western contends the WCAB's decision merged two periods of disability, contrary to the provisions of section 3208.2, and incorrectly applied section 5500.5 by holding the last carrier, Western, responsible for disability caused by one continuous, cumulative injury which first occurred during Industrial's period of coverage. We agree with the latter contention and will annul the WCAB's decision and remand for further proceedings. We reject a further claim by both Western and Industrial [**30] that the WCAB erroneously failed to apportion a percentage of Austin's disability to nonindustrial aggravating factors.

FACTS

Austin began working for Kirschenman Enterprises in 1962 as a farm laborer. Over the years, he was assigned increasing responsibilities and was ultimately promoted to superintendent in December 1984. In 1985, Austin began experiencing symptoms [***4] later diagnosed as major depression. He was nervous, confused, could not make decisions, and suffered memory loss. On June 19, 1985,

Austin was admitted to Kern View Community Mental Health Center and Hospital for evaluation and treatment. His treating physician was Dr. R.K. Shah. Austin was hospitalized from June 10 to July 26, 1985.

[*233] After his release from Kern View, Austin returned to work and resumed his duties as superintendent, although he remained under doctor's care and on medication. However, Austin had not fully recovered from his depression and his return to work precipitated the return of his symptoms. Austin's condition worsened. By March 1987, he could no longer perform the functions of his job and he obtained a work release from Dr. Shah. In 1988, Austin was again hospitalized for depression. His condition became permanent and stable on February 8, 1991.

All physicians consulted in the course of litigation, as well as Austin's treating physicians, agree that he suffers from major recurrent depression. The agreed medical examiner (AME), Dr. James H. Wells, reported that although there was some vague reference to earlier (pre-1985) bouts with depression, [***5] "there is no indication that depression would have occurred at this time or in this degree in the absence of the work experience described." Austin was unable to handle the increased technological demands of his work as the ranch grew and his job responsibilities increased. Dr. Wells also reported "the stress of the work environment as perceived and experienced by Mr. Austin, especially during the year immediately prior to the 1985 hospitalization served as a significant proximate cause and aggravating factor in the precipitation of the Major Depression with melancholia. Even though there was improvement there was never complete resolution of that episode so that the stress prior to 1985 played a significant role in the development of further destabilization of psychological defenses and the re-emergence of a full blown Major Depression . . .."

DISCUSSION

I. *STANDARD OF REVIEW*

CA(1) **(1)** ***HN1*** In considering a petition for writ of review of a decision of the WCAB, this court's authority is limited. This court must determine whether the evidence, when viewed in light of the entire record, supports the award of the WCAB. This court may not reweigh the evidence or decide disputed questions [***6] of fact. (§ 5952; *Universal City Studios, Inc. v. Worker's Comp. Appeals Bd.* (1979) 99 Cal.App.3d 647, 655- 656 [160 Cal.Rptr. 597].) However, this court is not bound to accept the WCAB's factual findings if determined to be unreasonable, illogical, improbable or inequitable when viewed in light of the overall statutory scheme. (*Bracken v. Workers' Comp. Appeals Bd.* (1989) 214 Cal.App.3d 246, 254 [262 Cal.Rptr. 537].) Questions of statutory interpretation are, of course, for this court to decide. (*Pestmaster Services, Inc. v. Structural Pest Control Bd.* (1991) 227 Cal.App.3d 903, 909 **[*234]** [278 Cal.Rptr. 281]; *Great Lakes Properties, Inc. v. City of El Segundo* (1977) 19 Cal.3d 152, 155 [137 Cal.Rptr. 154, 561 P.2d 244].)

II. *THE EVIDENCE SUPPORTS A FINDING THAT AUSTIN SUFFERED FROM ONE CUMULATIVE INJURY*

CA(2) **(2)** ***HN2*** Under the workers' compensation statute, there are two distinct types of industrial "injuries." A compensable injury can be either "specific" or "cumulative." (§ 3208.1.) [***7] A cumulative injury is one [**31] which results from repetitive events, occurring during each day's work, which in combination cause any disability or need for medical treatment. (*Fireman's Fund Indem. Co. v. Ind. Acc. Com.* (1952) 39 Cal.2d 831, 833 [250 P.2d 148].) A worker suffering from a cumulative injury may invoke the rights and benefits provided under California's workers' compensation laws when the cumulative effects of the repetitive events result in a compensable injury, i.e., one resulting in lost wages or the need for medical treatment. (See *Van Voorhis v. Workmen's Comp. Appeals Bd.* (1974) 37 Cal.App.3d 81, 86-87 [112 Cal.Rptr. 208]; *Hanna v. Workmen's Comp. Appeals Bd.* (1973) 32 Cal.App.3d 719, 722 [108 Cal.Rptr. 227].)

HN3 In any given situation, there can be more than one injury, either specific or cumulative or a combination of both, arising from the same event or from separate events. (*Chevron U.S.A., Inc. v. Workers' Comp. Appeals Bd.* (1990) 219 Cal.App.3d 1265, 1271 [268 Cal.Rptr. 699]; [***8] *City of Los Angeles v. Workers' Comp. Appeals Bd.* (1978) 88 Cal.App.3d 19, 29 [151 Cal.Rptr. 679]; *State Comp. Ins. Fund v. Workmen's Comp. App. Bd.* (1969) 1 Cal.App.3d 812, 819 [82 Cal.Rptr. 102].) The number and nature of the injuries suffered are questions of fact for the WCJ or the WCAB. (*Aetna Cas. & Surety Co. v. Workmen's Comp. Appeals Bd.* (1973) 35 Cal.App.3d 329, 341 [110 Cal.Rptr. 780]; *LeVesque v. Workmen's Comp. App. Bd.* (1970) 1 Cal.3d 627, 637 [83 Cal.Rptr. 208, 463 P.2d 432].) For example, if an employee becomes disabled, is off work and then returns to work

only to again become disabled, there is a question of fact as to whether the new disability is due to the old injury or whether it is due to a new and separate injury. (See *Assurance Corp. v. Industrial Acc. Com.* (1922) 57 Cal.App. 257, 259-260 [207 P. 60]; *Huston v. Workers' Comp. Appeals Bd.* (1979) 95 Cal.App.3d 856 [157 Cal.Rptr. 355].) [***9] In addition, ***HN4*** one exposure may result in two distinct injuries, posing another question of fact. (*Chevron U.S.A., Inc. v. Workers' Comp. Appeals Bd., supra,* 219 Cal.App.3d at p 1271.) If a worker not only suffers a nervous breakdown but also develops an ulcer as a result of work- related stress, there would be two distinct injuries from one exposure. The nature and the number of injuries suffered are determined by the **[*235]** events leading to the injury, the medical history of the claimant, and the medical testimony received.

CA(3) **(3)** Both the WCJ and the WCAB found Austin suffered from a single cumulative injury. This finding is supported by substantial evidence and binds this court on review. (*LeVesque v. Workmen's Comp. App. Bd., supra,* 1 Cal.3d at p. 637.) Dr. Wells opined even though Austin may have had a proclivity for depression prior to 1985, there was no evidence depression would have occurred absent the stress he suffered at work. Dr. Wells also reported that Austin never recovered from the depressive episode in 1985 and that he became progressively worse upon returning [***10] to work. It was the same stress that resulted in Austin's initial hospitalization in 1985 that further exacerbated the problem after he returned to work. Dr. Wells said the depressive episode that began in 1985 was never completely resolved. Austin remained under a doctor's care and on medication from 1985 onward. The WCAB's finding is also supported by Dr. Shah's discharge report and Austin's testimony. Austin may have improved for a short time after hospitalization, but he never recovered and his symptoms reappeared shortly after he returned to work, becoming progressively worse.

III. *AUSTIN'S INJURIES WERE NOT IMPERMISSIBLY MERGED*

CA(4a) **(4a)** Western contends the finding that Austin suffered from a single cumulative injury impermissibly merges two periods of continuous trauma. Western also argues the WCJ's finding that there were two periods of temporary disability is inconsistent with a finding that there was one cumulative injury.

CA(5) **(5)** ***HN5*** The workers' compensation statute provides indemnity for both temporary and permanent disabilities. A temporary [**32] disability is impairment reasonably expected to be cured or materially improved with proper medical care. (*Chavira v. Workers' Comp. Appeals Bd.* (1991) 235 Cal.App.3d 463, 473 [286 Cal.Rptr. 600].) [***11] A disability, other than one resulting from a progressive occupational disease, is permanent when the employee's condition has reached maximum improvement or the condition has become stationary for a reasonable period of time. (*Ibid.*) A disability cannot be both permanent and temporary at the same time. (*New Amsterdam Cas. Co. v. Ind. Acc. Com.* (1951) 108 Cal.App.2d 502, 507 [238 P.2d 1046].) When a disability changes from temporary to permanent, the permanent disability is considered a new and further disability. (*Ibid.*)

HN6 Temporary disability benefits are intended primarily to replace lost earnings. Permanent disability benefits are to compensate both for actual incapacity to work and for the physical impairment suffered. (*Chavira v. Workers' Comp. Appeals Bd., supra,* 235 Cal.App.3d at p. 473.) When there are **[*236]** two discrete periods of temporary disability, they are not merged into a single disability but are treated as separate entitlements to benefits. (1 Hanna, Cal. Law of Employee Injuries & Workers' Compensation (rev. 2d ed. 1991) Temporary Disability Benefits, § [***12] 7.05, pp. 7-27 through 7-28.)

Whether a disability is permanent or temporary is a question of fact. (1 Hanna, *op. cit. supra,* § 7.01[2], pp. 7-5 through 7- 6.)

CA(4b) **(4b)** Western argues the antimerger doctrine found in section 3208.2 requires a finding that there were at least two continuous cumulative injuries, not one. This is important in determining who bears responsibility for Austin's benefits, Western or Industrial. ***HN7*** Section 3208.2 provides as follows: "When disability, need for medical treatment, or death results from the combined effects of two or more injuries, either specific, cumulative, or both, all questions of fact and law shall be separately determined with respect to each such injury, including, but not limited to, the apportionment between such injuries of liability for disability benefits, the cost of medical treatment, and any death benefit."

HN8 Section 3208.2 applies to the combination of *injuries,* not periods of disability. Under section

3208.1, an injury causing a need for medical treatment is compensable even in the absence of disability. In this case Austin had a compensable injury from 1985 onward. Although he had two periods of disability, i.e., the inability [***13] to work, those two periods of disability were connected by a continuous need for medical treatment all caused by a single work-related cumulative injury, stress-induced depression. There was thus no time between 1985 and the present that Austin did not have a compensable injury.

CA(6) **(6)** The legislative intent of section 3208.2 was to nullify court decisions allowing the merger of past specific injuries into a cumulative injury. The court cases giving rise to the antimerger statute address, for the most part, past specific injuries to a worker which were merged into a later cumulative injury thus allowing recovery of benefits otherwise barred by the statute of limitations. The specific injuries were usually separated by periods when no compensable injury existed. When such injuries were merged into a later cumulative injury, insurance carriers who had already compensated the worker for the benefits due for the specific injuries were charged with a share of the disability benefits later due as a result of the cumulative injury. (See *Chavez v. Workmen's Comp. Appeals Bd.* (1973) 31 Cal.App.3d 5; 7-10 [106 Cal.Rptr. 853]; *State Comp. Ins. Fund v. Workmen's Comp. App. Bd., supra,* 1 Cal.App.3d 812, 817-818.) [***14] Merging defeated the purposes of the **[*237]** statute of limitations and left insurance carriers and employers open to risk for lengthy periods of time.

CA(4c) **(4c)** Western, in support of its position, relies on *Aetna Cas. & Surety Co. v. Workmen's Comp. Appeals Bd., supra,* 35 Cal.App.3d 329. In *Aetna,* the WCAB found that two specific incidents causing injury to the employee's back were [**33] part of a continuous trauma to the back and thus the injury could be classified as cumulative. However, because the record revealed two distinct periods of disability separated by periods *without compensable injury* and two specific incidents which gave rise to compensable injury, the antimerger doctrine precluded treating the two specific incidents as a single cumulative injury. The court found a finding of two distinct periods of disability and need for medical treatment was inconsistent with the finding of a single cumulative injury and annulled the award. (*Aetna Cas. & Surety Co. v. Workmen's Comp. Appeals Bd., supra,* 35 Cal.App.3d at pp. 342-343.)

Aetna is distinguishable from this case. [***15] Here Austin had only one continuous compensable injury. Unlike *Aetna,* Austin's two periods of temporary disability were linked by the continued need for medical treatment. The two periods of temporary disability were not "distinct" as was the case in *Aetna,* nor were they instigated by separate specific incidents.

The record supports the WCAB's findings. There was a single cumulative injury, despite separate periods of temporary disability. There was no impermissible merger.

IV. *SECTION 5500.5 WAS INCORRECTLY APPLIED*

CA(7a) **(7a)** Western contends the WCJ and WCAB incorrectly applied section 5500.5. *HN9* The section reads in part as follows: "(a) Except as otherwise provided in Section 5500.6, liability for occupational disease or cumulative injury claims filed or asserted on or after January 1, 1978, shall be limited to those employers who employed the employee during a period of four years immediately preceding either the date of injury, as determined pursuant to Section 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first. Commencing January 1, 1979, [***16] and thereafter on the first day of January for each of the next two years, the liability period for occupational disease or cumulative injury shall be decreased by one year so that liability is limited in the following manner:

[*238]

"For claims filed or asserted on or after:	**The period shall be:**

"January 1, 1979	three years
"January 1, 1980	two years
"January 1, 1981 and thereafter.	one year

"In the event that none of the employers during the above referenced periods of occupational disease or cumulative injury are insured for workers' compensation coverage or an approved alternative thereof, liability shall be imposed upon the last year of employment exposing the employee to the hazards of the occupational disease or cumulative injury for which an employer is insured for workers' compensation coverage or an approved alternative thereof.

"Any employer held liable for workers' compensation benefits as a result of another employer's failure to secure the payment of compensation as required by this division shall be entitled to reimbursement from the employers who were unlawfully uninsured during [***17] the last year of the employee's employment, and shall be subrogated to the rights granted to the employee against the unlawfully uninsured employers under the provisions of Article 1 (commencing with Section 3700) of Chapter 4 of Part 1 of Division 4.

"If, based upon all the evidence presented, the appeals board or workers' compensation judge finds the existence of cumulative injury or occupational disease, liability for the cumulative injury or occupational disease shall not be apportioned to prior or subsequent years; however, in determining the liability, evidence of disability due to specific injury, disability due to nonindustrial causes, or disability previously compensated for by way of a findings and award or order approving compromise and release, or a voluntary payment of disability, may be admissible for purposes of apportionment."

[**34] Pursuant to section 5412, 2 the date of a cumulative injury is the date the employee *first* suffers a "disability" and has reason to know the disability is work related. (*Hanna v. Workmen's Comp. Appeals Bd., supra,* 32 Cal.App.3d at p. 722.) Austin first suffered disability in June [***18] 1985 when he **[*239]** was hospitalized. Austin's testimony establishes that in 1985 he believed his problems were work related. 3

The WCJ relied on *California Casualty Indem. Exchange v. Workers' Comp. Appeals Bd.* (Murphy) (1991) 56 Cal.Comp.Cases 508, a case assigning liability pursuant to section 5500.5, as controlling.

In *Murphy* there was a cumulative injury which occurred during coverage provided by California Casualty and prior periods of disability for which another insurer provided benefits. [***19] Murphy worked in the kitchen of the St. Francis Yacht Club and as a result of his work duties developed a dermatological condition of the hands that required medical treatment and resulted in periods of temporary disability over a period of years. The WCAB upheld the WCJ's finding that a single cumulative injury resulted in 1979 and concluded that under section 5500.5, California Casualty was solely liable for the entire injury. The WCAB did not merge the earlier prior periods of disability, apparently because it found them distinct.

The facts are not fully reported in *Murphy* since writ review was denied, and the report appearing in the digest fails to state why liability was imposed on the later carrier. It appears from what is reported that the antimerger doctrine of section 3208.1 required a finding of more than one injury, the last being cumulative and beginning within the coverage period of California Casualty. Therefore, under sections 5412 and 5500.5, California Casualty was liable for the entire cumulative injury beginning within its coverage period and ending in permanent disability even though some of the causation of that injury could be attributed to earlier [***20] periods of disability. Assuming the previous periods of disability were distinct and separate, the statute was correctly applied because the date of the cumulative injury was the first date of disability for *that* injury.

However, the same result is not permitted here. In this case *HN11* there is but one continuous cumulative injury; under section 5500.5, liability for the entire injury is imposed upon the carrier who provided coverage during the year immediately preceding the *date of injury* or the *date of last exposure, whichever occurs first.* In *Murphy,* California Casualty was liable for the benefits owed regardless of which date controlled. In this case, Industrial is the carrier of liability because the "date of injury" occurred when Austin was first hospitalized in 1985, during Industrial's coverage period. This is the first occurring date under the statute, not the date of last exposure which fell during Western's coverage period.

[*240] Section 5500.5 was enacted in 1951 to codify the judicially created rule allowing an employee suffering from a progressive occupational disease to obtain an award against any one of the employers or carriers during the employment [***21] history. Under the rule, those successive employers or carriers would seek apportionment from each other. (*Flesher v. Workers' Comp. Appeals Bd.* (1979) 23 Cal.3d 322, 327 [152 Cal.Rptr. 459, 590 P.2d 35].) The statute was substantially amended in 1973. (Stats. 1973, ch. 1024, § 4, p. 2032.) As amended, the statute included cumulative injuries, limited the employers against whom compensation could be sought to those who had employed the injured worker during a preceding five-year period, and sharply curtailed the right to apportionment. (*Ibid.*)

[**35] In 1977, section 5500.5 was again amended. The liability period was reduced, in one-year increments, from the five-year period to a one-year period by 1981. (Stats. 1977, ch. 360, § 1, p. 1334.) In addition, all right of apportionment "to prior or subsequent years" was eliminated, together with an exception which had permitted contribution among insurers under limited circumstances. (*Ibid.*; see *City of Los Angeles v. Workers' Comp. Appeals Bd., supra,* 88 Cal.App.3d at p. 25; *Review of Selected 1977 California* [***22] *Legislation* (1978) 9 Pacific L.J. 687-691.)

The various amendments were favored by the insurance industry, which reasoned that "the total burdens and benefits upon employers and insurers would more or less even out, for while they might be required to assume a larger liability in some cases, they would also be absolved of liability in other cases." (*Flesher v. Workers' Comp. Appeals Bd., supra,* 23 Cal.3d at p. 328.)

As noted, the crucial date under section 5500.5 is either the date of injury as defined by section 5412, or the last date of exposure, whichever occurs first. In this case, the date of injury is June 1985. The last date of exposure was March 7, 1987. Thus, under the express language of section 5500.5, Industrial, who was the carrier in June 1985 and the immediately preceding year, bears full liability for the benefits owed Austin.

CA(8) **(8)** The Legislature is presumed to have meant what it said and the plain meaning of the language governs. (*Great Lakes Properties, Inc. v. City of El Segundo, supra,* 19 Cal.3d at p. 155.) When [***23] the words are clear, there is no room for interpretation. (*Regents of University of California v. Public Employment Relations Bd.* (1986) 41 Cal.3d 601, 607 [224 Cal.Rptr. 631, 715 P.2d 590].)

CA(7b) **(7b)** Industrial seizes on the following language in section 5500.5, subdivision (a): ". . . In determining the liability, evidence of disability **[*241]** . . . previously compensated for by way of a findings and award or order approving compromise and release, or a voluntary payment of disability, may be admissible for purposes of apportionment." Industrial makes a rather convoluted argument that because it had not "previously" compensated Austin for the 1985 period of disability, and because it did not provide coverage during the one-year period before the final industrial exposure, no part of the liability for the 1987 and subsequent disabilities could be apportioned to it.

We are not persuaded. Whatever application the provision relied upon may have in other factual situations, it does not nullify the express statutory language fixing liability for a single cumulative injury, as was found here, on those who employed the applicant [***24] during the earlier one-year period immediately preceding the date of injury.

The WCAB's decision incorrectly applies section 5500.5 and for that reason must be annulled.

V. *CONSIDERATION OF THE AME REPORT*

CA(9) **(9)** Western and Industrial both argue the WCAB should have given greater deference to the AME's apportionment of disability to the pre-1985 bouts of depression and Austin's purported proclivity to depression. According to Western, it is common practice to assign a percentage of present disability to a preexisting condition and apportion that percentage from the award made. (See *Franklin v. Workers' Comp. Appeals Bd.* (1978) 79 Cal.App.3d 224, 231 [145 Cal.Rptr. 22].)

Here the WCJ considered the AME's report carefully. In her report and recommendation to the WCAB on the petition for reconsideration, she noted that the doctor's conclusion that there was no indication depression would have developed in the absence of the work experience was inconsistent with his apportionment to a "pre-existing pattern of recurrent depression." In her award and in her report and recommendation on the petition for reconsideration, the WCJ states clearly [***25] she rejected the

insurers' claim that Austin's depression may have been caused in part by [**36] family problems. Western and Industrial have cited no authority requiring the WCJ, the WCAB or this court to accept the AME's recommended apportionment of liability. *HN12* Liability is a legal question determined with reference to the statutory scheme, not a medical question.

The report of the AME was carefully considered in light of the entire record. Nothing more was required.

[*242] DISPOSITION

The WCAB's decision after reconsideration is annulled, and the matter is remanded for further proceedings consistent with this opinion.

Martin, Acting P. J., and Vartabedian, J., concurred.

Respondents' petition for review by the Supreme Court was denied August 19, 1993.

Footnotes

1 All statutory references are to the Labor Code unless otherwise indicated.

2 "*HN10* The date of injury in cases of occupational diseases or cumulative injuries is that date upon which the employee first suffered disability therefrom and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment." (§ 5412.)

3 There is no statute of limitations problem presented in this case because the WCAB's findings on the statute of limitations issue are not challenged on appeal.

State Comp. Ins. Fund v. Workers' Comp. Appeals Bd., 119 Cal. App. 4th 998

Copy Citation

Reporter

119 Cal. App. 4th 998 * 14 Cal. Rptr. 3d 793 ** 69 Cal. Comp. Cases 579 *** 2004 Cal. App. LEXIS 1002 ****

STATE COMPENSATION INSURANCE FUND, Petitioner, v. WORKERS' COMPENSATION APPEALS BOARD and CALIFORNIA INSURANCE GUARANTEE ASSOCIATION, Respondents.

Notice: As modified July 20, 2004.

Subsequent History: Later proceeding at State Comp. Ins. Fund v. Workers' Comp. Appeals Bd., 2004 Cal. App. LEXIS 1144 (Cal. App. 2d Dist., July 20, 2004)

Prior History: [****1] W.C.A.B. No. VNO 374266. PROCEEDING to review a decision of the Workers' Compensation Appeals Board.

Disposition: Annulled and remanded.

Core Terms

disability, permanent disability, compensable, temporary disability, date of injury, Cases, modified, cumulative injury, occupational disease, filing claim, splints

Case Summary

Procedural Posture

Petitioner State Compensation Insurance Fund (California) sought review of an order of respondent Workers' Compensation Appeals Board (California), which affirmed an award in favor of an employee and (1) found that the date of cumulative trauma injury was the first day of compensable temporary disability, (2) dismissed real party in interest guarantee association, and (3) placed all liability on the Fund pursuant to Cal. Lab. Code § 5500.5.

Overview

The employee sustained a work-related injury. She was employed by two temporary placement agencies, but she worked for one company. The association administered claims for the first agency, and the Fund covered the second agency. The employee obtained medical care and was returned to work. She was later terminated. She then underwent surgery and was considered permanent and stationary by an agreed medical evaluator, who also found a single continuous trauma during the employment period. A workers' compensation judge found the date of injury to be the year preceding the termination. The Fund was ordered to pay the entire permanent disability award. The Fund argued that the injury was years prior to that determined, which preceded the Fund's coverage and fell within the association's coverage. The Board disagreed and held that "disability" meant compensable temporary disability, but the court annulled the decision. The court held that either compensable temporary disability or permanent disability was required to satisfy Cal. Lab. Code § 5412. On remand, the evaluator was given the chance to address whether permanent disability existed prior to the employee's last date of employment.

Outcome

The court annulled the Board's order and remanded for further proceedings.

LexisNexis® Headnotes

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Compensability > Occupational Diseases

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards > Types of Awards

Workers' Compensation & SSDI > ... > Claims > Statute of Limitations > General Overview

Workers' Compensation & SSDI > ... > Claims > Statute of Limitations > Claims Periods

Workers' Compensation & SSDI > Compensability > Injuries > General Overview

Workers' Compensation & SSDI > Compensability > Injuries > Cumulative Injuries

Workers' Compensation & SSDI > Compensability > Injuries > Successive Injuries

Workers' Compensation & SSDI > Exclusivity > General Overview

HN1 **Workers' Compensation, Occupational Diseases**
Cal. Lab. Code § 5500.5(a) provides that liability for occupational disease or cumulative injury claims shall be limited to those employers who employed the employee during the period of one year immediately preceding either the date of injury, as determined pursuant to Cal. Lab. Code § 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first.
More like this Headnote

Shepardize - Narrow by this Headnote

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Compensability > Occupational Diseases

Workers' Compensation & SSDI > Compensability > Injuries > Cumulative Injuries

HN2 **Workers' Compensation, Occupational Diseases**
See Cal. Lab. Code § 5412. More like this Headnote

Shepardize - Narrow by this Headnote

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Compensability > Occupational Diseases

Governments > Legislation > Statute of Limitations > Time Limitations

Workers' Compensation & SSDI > Compensability > Injuries > Cumulative Injuries

Governments > Legislation > Statute of Limitations > General Overview

Workers' Compensation & SSDI > ... > Claims > Statute of Limitations > General Overview

HN3 **Workers' Compensation, Occupational Diseases**
Cal. Lab. Code § 5405 provides that proceedings for benefits must commence within one year of the date of injury. Cases interpreting Cal. Lab. Code § 5412 for statute of limitations purposes hold that the date of injury is the date upon which employment activities cause compensable disability, and the statute of limitations does not begin to run until the last day of employment exposure to such activities, or the compensable disability caused by such activities, whichever is later. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Temporary Total Disabilities

HN4 **Benefit Determinations, Permanent Total Disabilities**
Although there is no compensable temporary disability until the worker suffers wage loss, wage loss is not required for an injured worker to be entitled to permanent disability compensation.
More like this Headnote

Shepardize - Narrow by this Headnote

Civil Procedure > Appeals > Standards of Review > De Novo Review

HN5 **Standards of Review, De Novo Review**

A question of law has a standard of review of de novo. More like this Headnote

Shepardize - Narrow by this Headnote

Labor & Employment Law > Employment Relationships > At Will Employment > Definition of Employees

Workers' Compensation & SSDI > Administrative Proceedings > General Overview

Labor & Employment Law > Disability & Unemployment Insurance > Disability Benefits > General Overview

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Temporary Total Disabilities

HN6 **At Will Employment, Definition of Employees**
Disability includes both temporary disability and permanent disability. If disability were construed as meaning only temporary disability, an employee who knew he or she had permanent disability could indefinitely delay in filing his or her application for workers' compensation benefits. The court does not believe the legislature intended such a result. More like this Headnote

Shepardize - Narrow by this Headnote

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Compensability > Occupational Diseases

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review > General Overview

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

Workers' Compensation & SSDI > Compensability > Injuries > General Overview

Workers' Compensation & SSDI > Compensability > Injuries > Cumulative Injuries

HN7 **Workers' Compensation, Occupational Diseases**
The primary concern of the court in other case law was the definition of "disability," as used in Cal. Lab. Code § 5412. Ratable permanent disability meets the requirement. Although the injury

in that case was a progressive occupational disease, the same reasoning applies to cumulative injury. More like this Headnote

Shepardize - Narrow by this Headnote

Governments > Legislation > Statute of Limitations > General Overview

Workers' Compensation & SSDI > Compensability > Injuries > Cumulative Injuries

Workers' Compensation & SSDI > ... > Claims > Statute of Limitations >

General Overview

HN8 **Legislation, Statute of Limitations**
A distinction is drawn between the time that the right to file a claim accrues and the time when it is barred. Under Cal. Lab. Code § 3208.1, any disability or need for medical treatment may give rise to a separate cumulative injury for which an applicant may file a claim, but the statute of limitations does not commence to run upon such an injury until compensable disability has occurred. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations >

Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Temporary Total Disabilities

HN9 **Benefit Determinations, Cumulative & Successive Disabilities**
The court concludes that the date of injury under Cal. Lab. Code § 5500.5 requires compensable temporary disability or permanent disability. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > Earning Capacity

Workers' Compensation & SSDI > Benefit Determinations > Temporary Total Disabilities

HN10 **Benefit Determinations, Earning Capacity**
Because actual wage loss is required for temporary disability, modified work alone is not a sufficient basis for compensable temporary disability. But, a modification may indicate a permanent impairment of earning capacity, especially if the worker is never able to return to the original job duties. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Compensability > Injuries > Cumulative Injuries

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Temporary Total Disabilities

HN11 **Injuries, Cumulative Injuries**
The court concludes that either compensable temporary disability or permanent disability is required to satisfy Cal. Lab. Code § 5412. Medical treatment alone is not disability, but it may be evidence of compensable permanent disability, as may a need for splints and modified work. These are questions for the trier of fact to determine and may require expert medical opinion.
More like this Headnote

Shepardize - Narrow by this Headnote

Headnotes/Syllabus

Summary

CALIFORNIA OFFICIAL REPORTS SUMMARY

The State Compensation Insurance Fund (State Fund) petitioned for reconsideration of a workers' compensation judge award in favor of an injured worker. The worker sustained work-related carpal tunnel and tendinitis in her right upper extremity while employed as an assembler at a sound equipment manufacturing plant. Although she worked continuously at one company, the worker was employed by two different temporary placement agencies. The first placement agency's insurer was in receivership, and the claims were administered by the California Insurance Guarantee Association (CIGA). The second placement agency was covered by the State Fund. The worker obtained medical care consisting of antiinflammatory medication, a wrist splint/brace, and physical therapy. The worker's treating physician permitted the worker to return to modified work. The worker continued working in modified positions at full salary, but without the manager's knowledge of her injury. When the manager discovered the worker's injury, the worker was terminated because she could not do the job for which she was hired. The workers' compensation judge dismissed CIGA, ordered the State Fund to pay the entire award, and ruled that filing the claim established the requisite knowledge for purposes of Lab. Code, § 5412, which governs when the date of injury in cases of occupational diseases or cumulative injuries occurs. The Workers' Compensation Appeals Board (WCAB) denied the State Fund's petition for reconsideration and affirmed the award, finding that the date of the worker's cumulative trauma injury was the first day of compensable temporary disability. Pursuant to Lab. Code, § 5500.5, the WCAB placed all liability on the State Fund.

The Court of Appeal annulled the WCAB's order and remanded for further proceedings. The court held that either compensable temporary disability or permanent disability can satisfy Lab. Code, § 5412. Medical treatment alone is not disability, but it may be evidence of compensable permanent disability, as may a need for splints and modified work. Actual wage loss is required

for **[*999]** temporary disability. Modified work alone is not a sufficient basis for compensable temporary disability. However, a modification may indicate a permanent impairment of earning capacity, especially if the worker is never able to return to the original job duties. Because the agreed medical evaluator had not addressed whether permanent disability existed prior to the worker's last date of employment, the evaluator was given the opportunity to do so on remand. (Opinion by Epstein, Acting P. J., with Hastings and Curry, JJ., concurring.)

Headnotes

CALIFORNIA OFFICIAL REPORTS HEADNOTES

Classified to California Digest of Official Reports

CA(1) **(1) Workers' Compensation § 68—Proceedings Before Workers' Compensation Appeals Board—Claims—Time for Filing—Date of Injury.**

Under Lab. Code, § 5405, which provides that proceedings for workers's compensation benefits must commence within one year of the date of injury, the date of injury is the date upon which employment activities cause compensable disability, and the statute of limitations does not begin to run until the last day of employment exposure to such activities, or the compensable disability caused by such activities, whichever is later. (Lab. Code, § 5412.)

CA(2) **(2) Workers' Compensation § 105—Benefits Recoverable—By Employee—Temporary and Permanent Disability—Wage Loss.**

Although there is no compensable temporary disability until a worker suffers wage loss, wage loss is not required for an injured worker to be entitled to permanent disability compensation.

CA(3) **(3) Workers' Compensation § 127—Judicial Review—Scope—De Novo Review.**

Where the facts in a workers' compensation case are not in dispute, the question is one of law, and the standard of review is de novo.

CA(4) **(4) Workers' Compensation § 105—Benefits Recoverable—By Employee—Temporary and Permanent Disability.**

Disability under the Workers' Compensation Law includes both temporary disability and permanent disability.

CA(5) **(5) Workers' Compensation § 105—Benefits Recoverable—By Employee—Temporary and Permanent Disability—Date of Injury.**

The date of injury under Lab. Code, § 5500.5, requires compensable temporary disability or permanent disability.

CA(6) **(6) Workers' Compensation § 105—Benefits Recoverable—By Employee—Temporary and Permanent Disability—Worker Unable to Return to Original Job Duties.**

Because actual wage loss is required for temporary disability, modified work alone is not a sufficient basis for compensable temporary disability. But, a modification may indicate a permanent impairment of earning capacity, especially if the worker is never able to return to the original job duties.

CA(7) **(7) Workers' Compensation § 105—Benefits Recoverable—By Employee—Temporary and Permanent Disability—Date of Injury—Medical Treatment—Expert Medical Opinion—Agreed Medical Evaluator—Existence of Permanent Disability Prior to Last Date of Employment.**

Either compensable temporary disability or permanent disability is required to satisfy Lab. Code, § 5412, which governs when the date of injury in cases of occupational diseases or cumulative injuries occurs. Medical treatment alone is not disability, but it may be evidence of compensable permanent disability, as may a need for splints and modified work. These are questions for the trier of fact to determine and may require expert medical opinion.

[2 Witkin, Summary of Cal. Law (9th ed. 1987) Workers' Compensation, § 366.]

▼ California Compensation Headnotes/Summary

Headnotes

Cumulative Trauma > Date of Injury

Court of Appeal, annulling and remanding decision of WCAB, held that apportioning *liability for cumulative trauma injuries, pursuant to Labor Code § 5500.5, requires* either compensable temporary disability or permanent disability to satisfy disability requirement of Labor Code § 5412, that because actual wage loss is required for temporary disability, modified work alone is not sufficient basis for compensable

temporary disability but may indicate permanent impairment of earning capacity, [*580] especially if worker is never able to return to original job duties, that medical treatment alone is not disability but may be evidence of compensable permanent disability, as may need for modified work, and that these are questions for trier of fact to determine and may require expert medical opinion.** [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § § 4.71, [**2] 24.03[7][a], [b], 31.13[2][a]-[d].]

Counsel: Richard A. Krimen, Robert W. Daneri and Don E. Clark for Petitioner.

No appearance for Respondent Workers' Compensation Appeals Board.

Griffin & Griffin, Sybil R. Zanger; Guilford Steiner Sarvas & Carbonara and Richard E. Guilford for Respondent California Insurance Guarantee Association.

Judges: Epstein, Acting P. J., with Hastings and Curry, JJ., concurring.

Opinion by: EPSTEIN

Opinion

[**794] **EPSTEIN, Acting P. J.**—State Compensation Insurance Fund (State Fund) seeks review of an order of the Workers' Compensation Appeals Board (the **[*1001]** Board). The order denied the State Fund's petition for reconsideration and, instead, affirmed an award in favor of Monica Rodarte finding the date of cumulative trauma injury was the first day of compensable temporary disability and placing all liability on State Fund pursuant to Labor Code section 5500.5. [1] State Fund contends the legal date of injury was some 11 months before, when her treating physician prescribed a splint and she returned to modified work duties. The Board's opinion masks the true issue, [****2] which is whether permanent disability can satisfy section 5412. [2] We hold that it can. We shall annul the Board's order and remand for further proceedings consistent with this opinion.

[****3] FACTUAL AND PROCEDURAL SUMMARY [3]

The facts are undisputed. Monica Rodarte sustained work-related carpal tunnel [**795] and tendinitis in her right upper extremity while employed as an assembler at a sound equipment manufacturing plant from 1995 through August 8, 1998. Although she worked continuously at one company, Acoustic Authority, she was actually employed by two different temporary placement agencies—Apple One for the period April 1995 to February 28, 1998, and Temptrak for the period March 1, 1998 to August 7, 1998. Apple One's insurer is in liquidation and the claims are [****4] [***581] administered by California Insurance Guarantee Association (CIGA). Temptrak was covered by State Fund.

Rodarte obtained medical care consisting of antiinflammatory medication, a wrist splint/brace and

physical therapy beginning October 3, 1997. The treating physician permitted her to return to modified work. Rodarte filed a claim for benefits in October 1997.

Acoustic Authority's supervisors accommodated Rodarte's injury and she continued working in modified positions at full salary, but without the **[*1002]** manager's knowledge of her injury. On August 7, 1998, when the manager discovered Rodarte's injury, she was terminated because she could not do the job for which she was hired. [4] Rodarte testified that she would have continued working had she not been terminated.

Rodarte underwent surgery. She was considered permanent and stationary by an agreed medical evaluator as of May 31, 2000. The agreed medical evaluator found a single continuous trauma [****5] during the entire employment period, from April 4, 1995 until Rodarte stopped working in August 1998.

The workers' compensation judge found the date of injury to be August 7, 1997 to August 7, 1998 (the year preceding her termination) and that Rodarte had a permanent disability rating of 27 percent. CIGA was dismissed and State Fund was ordered to pay the entire award. [5] The judge ruled that filing the claim established the requisite knowledge for section 5412.

State Fund petitioned for reconsideration, contending the date of injury was incorrect. It pointed out that Rodarte had filed a claim form in October 1997, when she received splints and was placed on modified [****6] duty. Thus, State Fund asserts that in October 1997 disability and knowledge of work-relatedness coincided. Therefore, State Fund contends, pursuant to sections 5412 and 5500.5, the correct date of injury should be October 1996 to October 1997. That entire period precedes State Fund's coverage and falls wholly during CIGA's coverage.

The Board disagreed, holding that "disability" means compensable temporary disability; that is, time lost from work, citing *County of Los Angeles v. Workers' Comp. Appeals Bd. (Gregg)* (1982) 47 Cal.Comp.Cases 1215 and *Christians v. California Cas. Indem. Exch.* (1975) 3 Cal. Workers' Comp. Rptr. 114. On that basis, the Board concluded that Rodarte was not temporarily disabled until after she left employment on August 7, 1998.

[**796] ***HN3*** ***CA(1)*** **(1)** Section 5405 provides that proceedings for benefits must commence within one year of the date of injury. Cases interpreting section 5412 for statute of limitations [***582] purposes hold that the date of injury is the date upon which employment activities cause *compensable* disability, and the statute of limitations does not begin to run until the last day of employment exposure to such activities, or the compensable disability caused by [****7] such activities, whichever is later. (§ 5412; *Hooker v. Workmen's Comp. Appeals Bd.* (1974) 36 Cal. App. 3d 698, 706 [111 Cal. Rptr. 766]; *Beveridge v. Industrial Acc.* **[*1003]** *Com.* (1959) 175 Cal. App. 2d 592 [346 P.2d 545]; *Ferguson v. City of Oxnard* (1970) 35 Cal.Comp.Cases 452 (en banc).) ***HN4*** ***CA(2)*** **(2)** Although there is no compensable temporary disability until the worker suffers wage loss (*Herrera v. Workmen's Comp. App. Bd. (Goleta Lemon Assn.)* (1969) 71 Cal.2d 254, 257 [78 Cal. Rptr. 497, 455 P.2d 425]), wage loss is not required for an injured worker to be entitled to permanent disability compensation. (See *Dept. of Motor Vehicles v. Indus. Acc. Com. (Dinan)* (1939) 14 Cal.2d 189 [93 P.2d 131]; see *Smith v. Industrial Acc. Com.* (1955) 44 Cal. 2d 364, 367 [282 P.2d 64].)

DISCUSSION

CA(3) **(3)** Since the facts are not in dispute, ***HN5*** the question is one of law and the standard of review is de novo. (*Reinert v. Industrial Acc. Com.* (1956) 46 Cal. 2d 349, 358 [294 P.2d 713].)

Relying on *Chavira v. Workers' Comp. Appeals Bd.* (1991) 235 Cal. App. 3d 463, 474 [286 Cal. Rptr. 600], State Fund argues that disability is not limited to temporary disability but [****8] includes permanent disability and does not require time lost from work. Alternatively, State Fund contends that if lost time is required, modified work accommodating the injury should be considered sufficient disability because Rodarte would have been entitled to temporary disability compensation if she had

not been given the opportunity to accommodate her injury by modifying her work duties.

CIGA argues that *Chavira* is distinguishable because it does not consider the definition of disability in section 5412. Instead, this case concerns the deficiency in the definition of permanent disability in the California Code of Regulations provision that governs progressive occupational diseases such as asbestosis. It does not concern cumulative trauma injuries.

At oral argument, CIGA's attorney asserted that Rodarte did not have knowledge of disability as required by section 5412. The workers' compensation judge found the knowledge requirement was satisfied when Rodarte filed the claim. Furthermore, CIGA conceded in its answer to the petition that Rodarte knew the injury was work related. There is no requirement that the degree of disability be known. The point is a moot issue [****9] in this case.

I

HN6 ***CA(4)*** **(4)** Disability includes both temporary disability and permanent disability. (*Chavira v. Workers' Comp. Appeals Bd., supra,* 235 Cal. App. 3d at p. 474; see also *J. T. Thorp, Inc. v. Workers' Comp. Appeals Bd.* (1984) 153 Cal. App. 3d 327 [200 Cal. [***583] Rptr. 219].) "If 'disability' were construed as **[*1004]** meaning only temporary disability, an employee who knew he [or she] had permanent disability could indefinitely delay in filing his [or her] application for workers' compensation benefits. We do not believe the Legislature intended such a result." (*Chavira, supra,* at p. 474.)

Chavira also discussed the regulatory definition of ratable subjective permanent [**797] disability. (*Chavira v. Workmen's Comp. Appeals Bd., supra,* 235 Cal. App. 3d at p. 475.) The court held that a physician's description that the employee had *mild* restrictive ventilatory defect was not *ratable* permanent disability. [6] Consequently, there was no compensable permanent disability sufficient for section 5412. ***HN7*** The primary concern of the court was the definition of "disability" as used in section 5412. Ratable permanent disability meets the requirement. Although the injury in *Chavira* was a progressive [****10] occupational disease, the same reasoning applies to cumulative injury. (*Chavez v. Workmen's Comp. Appeals Bd.* (1973) 31 Cal. App. 3d 5 [106 Cal. Rptr. 853].)

II

Some Board decisions have based the date of injury under section 5412 on compensable permanent disability. But on occasion, the Board has expressed the view that only temporary disability, that is compensable wage loss, would suffice. That was the position it expressed in this case. The Board's inconsistency is apparent [****11] in a series of decisions involving cumulative hearing loss, two of which are the very decisions relied on by the Board in this case: *Gregg* and *Christians* required lost time as a basis for finding compensable disability for the cumulative hearing loss injuries. But *Lackey v. Workers' Comp. Appeals Bd.* (1987) 52 Cal.Comp.Cases 350 and *Deaver v. Neilsen-Nickels Co.* (1988) 16 Cal. Workers' Comp. Rptr. 139, did not impose that requirement. In *Lackey* and *Deaver*, the Board held that gradual onset of hearing loss known to be an employment-related disability was sufficient to start the statute of limitations running, even though there is no lost time from work. In other words, *Gregg* and *Christians* required compensable temporary disability, but *Deaver* and *Lackey* did not, finding instead that permanent disability was sufficient.

[*1005] III

When the issue is not simply application of section 5412 for statute of limitations purposes but rather apportionment of liability pursuant to section 5500.5, the Board has further confused the issue by apportioning liability based on when the right to file a claim accrues under section 3208.1, and ignoring [****12] the disability requirement [***584] of section 5412. [7] (See *American Bridge Co. v. Workers' Comp. Appeals Bd.* (1995) 60 Cal.Comp.Cases 869 [date of injury was when need for medical treatment arose]; and *Travelers Property Casualty v. Workers' Comp. Appeals Bd. (Wright)* (2000) 65 Cal.Comp.Cases 884 [finding need for treatment constituted cumulative injury, citing section 3208.1].)

But on facts similar to those in the present case, in *Allianz Ins. Group v. Workers' Comp. Appeals Bd. (Hinojosa)* (1994) 64 Cal.Comp.Cases 83, [****13] the Board found a date of injury based on permanent [**798] disability to have occurred when the injured worker sought medical treatment for carpal tunnel syndrome and was supplied with wrist splints to wear at work. The Board noted that the employee had suffered from the condition for one and one-half years without missing any work time. It cited *Zenith Ins. Co. v. Workers' Comp. Appeals Bd.* (1998) 63 Cal.Comp.Cases 495, which recorded a similar result citing *Chavira*.

HN9 ***CA(5)*** **(5)** We conclude that the date of injury under section 5500.5 requires compensable temporary disability *or* permanent disability.

IV

HN10 ***CA(6)*** **(6)** Because actual wage loss is required for temporary disability, modified work alone is not a sufficient basis for compensable *temporary* disability. But, a modification may indicate a *permanent* impairment of earning capacity, especially if the worker is never able to return to the original job duties. (See *Allianz Ins. Group v. Workers' Comp. Appeals Bd., supra*, 64 Cal.Comp.Cases 83; see also *Zenith Ins. Co. v. Workers' Comp. Appeals Bd., supra*, 63 Cal.Comp.Cases 495.)

V

CA(7) **(7)** In summary, ***HN11*** we conclude that either compensable [****14] temporary disability or permanent disability is required to satisfy section 5412. Medical **[*1006]** treatment alone is not disability, but it may be evidence of compensable permanent disability, as may a need for splints and modified work. These are questions for the trier of fact to determine and may require expert medical opinion.

Here, the agreed medical evaluator did not address whether permanent disability existed prior to the last date of employment. He should be given the opportunity to do so on remand.

DISPOSITION

We annul the Board's order and remand for further proceedings consistent with this opinion.

[***585] Hastings, J., and Curry, J., concurred.

On July 20, 2004, the opinion was modified to read as printed above.

Footnotes

1 *HN1* Section 5500.5, subdivision (a) provides that liability for occupational disease or cumulative injury claims shall be limited to those employers who employed the employee during the period of one year "immediately preceding either the date of injury, as determined pursuant to Section 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first."

All further statutory references are to the Labor Code unless otherwise noted.

2 Section 5412 provides that *HN2* "[t]he date of injury in cases of occupational diseases or cumulative injuries is that date upon which the employee first suffered disability therefrom and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment."

3 The Board's record of proceedings was destroyed in accordance with California Code of Regulations, title 8, section 10758, which permits destruction of files more than five years from the filing of the case-opening document. The parties have agreed that the exhibits attached to the briefs filed with the court substantially recreate the record and that we may render our decision based on those exhibits.

4 No issues regarding the termination are raised on this review.

5 Even though CIGA covered some of the period, it was relieved of liability on the ground that this is a single cumulative injury and there is other insurance available. (Ins. Code, § 1063.1, subd. (c)(9); *Industrial Indemnity Co. v. Workers' Comp. Appeals Bd. (Garcia)* (1997) 60 Cal.App.4th 548 [70 Cal. Rptr. 2d 295].)

6 Thurber, Evalutaion of Industrial Disability (2d ed. 1960). (See Cal. Code Regs., tit. 8, §§ 9725, 9727.) Section 9727, subdivision 4 provides: "The terms shown below are presumed to

mean the following: ... [¶] 4. A *minimal* (mild) pain would constitute an annoyance, but causing no handicap in the performance of the particular activity, would be considered as nonratable permanent disability."

7 ***HN8*** A distinction is drawn between the time that the right to file a claim accrues and the time when it is barred. Under section 3208.1, *any* disability or need for medical treatment may give rise to a separate cumulative injury for which an applicant may file a claim, but the statute of limitations does not commence to run upon such an injury until *compensable* disability has occurred. (*Hooker v. Workmens Comp. Appeals Bd., supra,* 36 Cal. App. 3d at p. 706.)

Content Type: Cases

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Benson v. Workers' Comp. Appeals Bd., 170 Cal. App. 4th 1535

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Reporter

170 Cal. App. 4th 1535 * 89 Cal. Rptr. 3d 166 ** 2009 Cal. App. LEXIS 164 ***

DIANE BENSON, Petitioner, v. WORKERS' COMPENSATION APPEALS BOARD and THE PERMANENTE MEDICAL GROUP, Respondents.

Subsequent History: Review denied by Benson (Dianne) v. Workers' Compensation Appeals Board, 2009 Cal. LEXIS 4111 (Cal., Apr. 29, 2009)

Prior History: [***1] Workers' Compensation Appeals Board, Case Nos. OAK0297895, OAK0326228.

Core Terms

apportionment, permanent disability, industrial injury, disability, injuries, workers' compensation, sections, repeal, industrial, percentage of permanent disability, plain language, permanent, Italics,

factors, legislative history, causation, causes, Citations, statutes, statutory language, apportion, awards, legislative intent, approximate, occurring, abrogate, benefits, compensated, provides, rating

Case Summary

Procedural Posture

Petitioner employee sought review of a decision of respondent California Workers' Compensation Appeals Board, which granted her a total of $ 49,210, in two separate awards, based on a determination that two industrial injuries to her neck each caused 31 percent permanent disability.

Overview

The employee argued that she was entitled to a single award of $ 67,016 because she suffered a combined permanent disability from both injuries of 62 percent. The court held that the doctrine of Wilkinson v. Workers' Compensation Appeals Bd. (1977) 19 Cal.3d 491 was inconsistent with the apportionment reforms enacted by Sen. Bill No. 899. A system of apportionment based on causation in Lab. Code, §§ 4663 and 4664, required that each distinct industrial injury be separately compensated based on its individual contribution to a permanent disability. While there could be limited circumstances when the evaluating physician could not parcel out, with reasonable medical probability, the approximate percentages to which each distinct industrial injury causally contributed to an employee's overall permanent disability, that was not the situation in the instant case. The court concluded that the Board properly made two awards of 31 percent permanent disability each based on an agreed medical examiner's opinion that the employee's permanent partial disability was equally caused by cumulative trauma through June 3, 2003 and the specific injury of June 3, 2003.

Outcome

The court affirmed the Board's decision.

▼ LexisNexis® Headnotes

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards > Types of Awards

HN1 **Benefit Determinations, Cumulative & Successive Disabilities**
Apportionment is the process employed to segregate the residuals of an industrial injury from those attributable to other industrial injuries, or to nonindustrial factors, in order to fairly allocate the legal responsibility. More like this Headnote

Shepardize - Narrow by this Headnote

Administrative Law > Judicial Review > Standards of Review > Deference to Agency Statutory Interpretation

Workers' Compensation & SSDI > ... > Judicial Review > Standards of Review > General Overview

HN2 **Standards of Review, Deference to Agency Statutory Interpretation**
When a workers' compensation decision rests on the California Workers' Compensation Appeals Board's erroneous interpretation of the law, a reviewing court will annul the decision. The Board's conclusions on questions of law are reviewed de novo. When the reviewing court is asked to interpret and apply a statute to undisputed facts, the review is de novo. More like this Headnote

Shepardize - Narrow by this Headnote

Governments > Legislation > Interpretation

HN3 **Legislation, Interpretation**
When interpreting a statute, a reviewing court's purpose is to effectuate the legislature's intent. In construing a statute, the court's first task is to look to the language of the statute itself. When the language is clear and there is no uncertainty as to the legislative intent, the court should look no further and simply enforce the statute according to its terms. If possible, significance should be given to every word, phrase, sentence, and part of an act in pursuance of the legislative purpose. When used in a statute, words must be construed in context, keeping in mind the nature and obvious purpose of the statute where they appear. Moreover, the various parts of a statutory enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole. If the statutory language is susceptible to more than one reasonable interpretation, the courts look to extrinsic aids, including the ostensible objects to be achieved, the evils to be remedied, the legislative history, public policy, contemporaneous administrative construction, and the statutory scheme of which

the statute is a part. More like this Headnote

Shepardize - Narrow by this Headnote

Administrative Law > Judicial Review > Standards of Review >

Deference to Agency Statutory Interpretation

Governments > Legislation > Interpretation

Workers' Compensation & SSDI > ... > Judicial Review > Standards of Review >

Clearly Erroneous Standard of Review

HN4 **Standards of Review, Deference to Agency Statutory Interpretation**
In interpreting the workers' compensation statutes, a court gives great weight to the construction of the California Workers' Compensation Appeals Board, unless it is clearly erroneous or unauthorized. On the other hand, the workers' compensation statutes shall be *liberally construed by the courts with the purpose of extending their benefits for the protection* of persons injured in the course of their employment. Lab. Code, § 3202. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Compensability > Injuries > General Overview

HN5 **Compensability, Injuries**
Lab. Code, § 3208, defines "injury" as any injury or disease arising out of the employment. Under Lab. Code, § 3208.1, an injury may be either: (a) specific, occurring as the result of one incident or exposure that causes disability or need for medical treatment; or (b) cumulative, occurring as repetitive mentally or physically traumatic activities extending over a period of *time, the combined effect of which causes any disability or need for medical treatment. The date* of a cumulative injury shall be the date determined under Lab. Code, § 5412. A compensable injury is one that causes disability or need for medical treatments. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

HN6 **Benefit Determinations, Permanent Partial Disabilities**
The California Labor Code does not define "permanent disability." However, permanent disability is understood as the irreversible residual of an injury. Permanent disability payments are intended to compensate workers for both physical loss and the loss of some or all of their future earning capacity. The administrative regulations provide that a disability is considered permanent when an employee has reached maximal medical improvement, meaning his or her

condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment. Cal. Code Regs., tit. 8, § 10152. The individual physical and mental abnormalities resulting from injury are referred to as factors of permanent disability. The individual factors taken together constitute the entire permanent disability. More like this Headnote

Shepardize - Narrow by this Headnote

Governments > State & Territorial Governments > Legislatures

HN7 **State & Territorial Governments, Legislatures**
The California Constitution confirms the legislature's plenary power to create, and enforce a complete system of workers' compensation, by appropriate legislation. Cal. Const., art. XIV, § 4. In 2004, the legislature exercised that power by enacting omnibus reform of the workers' compensation statutes. Sen. Bill No. 899 was an urgency measure designed to alleviate a perceived crisis in skyrocketing workers' compensation costs. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

HN8 **Benefit Determinations, Permanent Partial Disabilities**
See Lab. Code, § 4664, subd. (a). More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations >

Cumulative & Successive Disabilities

HN9 **Benefit Determinations, Cumulative & Successive Disabilities**
See Lab. Code, § 4663. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations >

Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards >

Types of Awards

HN10 **Benefit Determinations, Cumulative & Successive Disabilities**
See Lab. Code, § 4664, subd. (b). More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards > Types of Awards

HN11 **Benefit Determinations, Cumulative & Successive Disabilities**
Lab. Code, § 4664, subd. (b), was intended to reverse the rule based on former Lab. Code, § 4750, which permitted an injured employee to show rehabilitation of an injury for which a permanent disability award had already been issued. More like this Headnote

Shepardize - Narrow by this Headnote

Governments > Legislation > Interpretation

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

HN12 **Legislation, Interpretation**
The plain language of the new statutory scheme for workers' compensation requires apportionment to each cause of a permanent disability, including each distinct industrial injury. This conclusion is compelled by: (1) the plain language of current Lab. Code, §§ 4663 and 4664; (2) the repeal of former Lab. Code, § 4750; (3) the legislative history; and (4) the deference courts owe the California Workers' Compensation Appeals Board's interpretation of workers' compensation statutes. More like this Headnote

Shepardize - Narrow by this Headnote

Governments > Legislation > Interpretation

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards > Types of Awards

HN13 **Legislation, Interpretation**
Lab. Code, §§ 4663 and 4664, do not support an argument that the legislature only intended to protect employers from liability for permanent disability previously compensated or not caused by their employment. The legislature's use of the phrase "the injury" in § 4664, subd. (a),

necessarily implies that each distinct industrial injury must be separately compensated. Furthermore, the plain language of § 4663, subd. (a), makes clear that the focus is no longer on the permanent disability itself, but its causes. "Apportionment based on causation" is not naturally limited to apportionment to nonindustrial causes and previous permanent disability awards. Rather, "apportionment based on causation" must mean apportionment to all causes, including each distinct industrial injury. Had the legislature intended to insulate certain causes from apportionment, it would have said so. This understanding is confirmed by the plain language of § 4663, subd. (c). Again, the legislature required assessment of the approximate percentage of permanent disability caused by the direct result of injury and not injuries. § 4663, subd. (c). The plain language of § 4663, subd. (c), read in conjunction with the rest of the statutory scheme, suggests the legislature's intent to require apportionment on an injury-by-injury basis, and no longer only for previous permanent disability. More like this Headnote

Shepardize - Narrow by this Headnote

Governments > Legislation > Interpretation

HN14 **Legislation, Interpretation**
The legislature does not intend to overthrow long-established principles of law unless such intention is clearly expressed or necessarily implied. More like this Headnote

Shepardize - Narrow by this Headnote

Administrative Law > Judicial Review > Standards of Review >

Deference to Agency Statutory Interpretation

Workers' Compensation & SSDI > ... > Judicial Review > Standards of Review >

General Overview

HN15 **Standards of Review, Deference to Agency Statutory Interpretation**
The California Workers' Compensation Appeals Board has extensive expertise in interpreting and applying the workers' compensation scheme. Consequently, courts give weight to its interpretations of workers' compensation statutes unless they are clearly erroneous or unauthorized. More like this Headnote

Shepardize - Narrow by this Headnote

Administrative Law > Judicial Review > Standards of Review >

Deference to Agency Statutory Interpretation

Workers' Compensation & SSDI > ... > Judicial Review > Standards of Review >

Clearly Erroneous Standard of Review

HN16 **Standards of Review, Deference to Agency Statutory Interpretation**

The California Workers' Compensation Appeals Board's conclusion that Sen. Bill No. 899 superseded the doctrine of Wilkinson v. Workers' Compensation Appeals Bd. (1977) 19 Cal.3d 491 is not clearly erroneous and is entitled to deference. More like this Headnote

Shepardize - Narrow by this Headnote

Governments > Legislation > Interpretation

Workers' Compensation & SSDI > Benefit Determinations >

Cumulative & Successive Disabilities

HN17 **Legislation, Interpretation**
Lab. Code, § 3202, provides that the workers' compensation statutes shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment. However, § 3202 is a tool for resolving statutory ambiguity where it is not possible through other means to discern the legislature's actual intent. Section 3202 cannot supplant the intent of the legislature as expressed in a particular statute. If the legislature's intent appears from the language and context of the relevant statutory provisions, then courts must effectuate that intent, even though the particular statutory language is contrary to the basic policy of the workers' compensation law. Because the legislature's intent is ascertainable from the language of the new apportionment statutes and the legislative history, courts cannot rely on § 3202 to defeat that intent. More like this Headnote

Shepardize - Narrow by this Headnote

Governments > Legislation > Interpretation

Workers' Compensation & SSDI > Benefit Determinations >

Cumulative & Successive Disabilities

HN18 **Legislation, Interpretation**
The plain language of current Lab. Code, §§ 4663 and 4664, as well as the California Supreme Court, make clear that apportionment is required for each distinct industrial injury causing a permanent disability, regardless of the temporal occurrence of permanent disability or the injuries themselves. The only relevant inquiry is whether separate and distinct industrial injuries have been sustained. If so, then each injury must stand on its own. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations >

Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards >

Types of Awards

HN19 **Benefit Determinations, Cumulative & Successive Disabilities**
The doctrine of Wilkinson v. Workers' Compensation Appeals Bd. (1977) 19 Cal.3d 491 is inconsistent with the apportionment reforms enacted by Sen. Bill No. 899. A system of apportionment based on causation requires that each distinct industrial injury be separately compensated based on its individual contribution to a permanent disability. There may be limited circumstances when the evaluating physician cannot parcel out, with reasonable medical probability, the approximate percentages to which each distinct industrial injury causally contributed to the employee's overall permanent disability. In such limited circumstances, when the employer has failed to meet its burden of proof, a combined award of permanent disability may still be justified. Lab. Code, § 4663, subd. (c). More like this Headnote

Shepardize - Narrow by this Headnote

▼ Headnotes/Syllabus

Summary

CALIFORNIA OFFICIAL REPORTS SUMMARY

The Workers' Compensation Appeals Board granted an employee a total of $ 49,210, in two separate awards, based on a determination that two industrial injuries to her neck each caused 31 percent permanent disability. The employee's combined permanent disability rating was 62 percent, after adjustment for age and occupation.

The Court of Appeal affirmed the board's decision. The court held that the doctrine of *Wilkinson v. Workers' Compensation Appeals Bd.* is inconsistent with the apportionment reforms enacted by Sen. Bill No. 899 (2003–2004 Reg. Sess.). The court agreed with the board that a system of apportionment based on causation in Lab. Code, §§ 4663 and 4664, requires that each distinct industrial injury be separately compensated based on its individual contribution to a permanent disability. Sections 4663 and 4664 do not support the employee's argument that the Legislature only intended to protect employers from liability for permanent disability previously compensated or not caused by their employment. The court also agreed with the board that there may be limited circumstances when the evaluating physician cannot parcel out, with reasonable medical probability, the approximate percentages to which each distinct industrial injury causally contributed to an employee's overall permanent disability. In such limited circumstances, when the employer has failed to meet its burden of proof, a combined award of permanent disability may still be justified. However, that was not the situation in the instant case. The court concluded that the board properly made two awards of 31 percent permanent disability each based on an agreed medical examiner's opinion that the employee's permanent partial disability was equally caused by cumulative trauma through June 3, 2003. and the specific injury of June 3, 2003. (Opinion by Haerle ▾, J., with Kline ▾, P. J., and Richman, J. ▾, concurring.) **[*1536]**

Headnotes

CALIFORNIA OFFICIAL REPORTS HEADNOTES

CA(1) **(1) Statutes § 29—Construction—Language—Legislative Intent—Context—Use of Extrinsic Aids.**

When interpreting a statute, a reviewing court's purpose is to effectuate the Legislature's intent. In construing a statute, the court's first task is to look to the language of the statute itself. When the language is clear and there is no uncertainty as to the legislative intent, the court should look no further and simply enforce the statute according to its terms. If possible, significance should be given to every word, phrase, sentence, and part of an act in pursuance of the legislative purpose. When used in a statute, words must be construed in context, keeping in mind the nature and obvious purpose of the statute where they appear. Moreover, the various parts of a statutory enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole. If the statutory language is susceptible to more than one reasonable interpretation, the courts look to extrinsic aids, including the ostensible objects to be achieved, the evils to be remedied, the legislative history, public policy, contemporaneous administrative construction, and the statutory scheme of which the statute is a part.

CA(2) **(2) Workers' Compensation § 5—Construction of Statutes—Deference to Workers' Compensation Appeals Board.**

In interpreting the workers' compensation statutes, a court gives great weight to the construction of the Workers' Compensation Appeals Board, unless it is clearly erroneous or unauthorized.

CA(3) **(3) Workers' Compensation § 2—Definitions—Injury.**

Lab. Code, § 3208, defines "injury" as any injury or disease arising out of the employment. Under Lab. Code, § 3208.1, an injury may be either: (a) specific, occurring as the result of one incident or exposure that causes disability or need for medical treatment; or (b) cumulative, occurring as repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment. The date of a cumulative injury shall be the date determined under Lab. Code, § 5412. A compensable injury is one that causes disability or need for medical treatments.

CA(4) **(4) Workers' Compensation § 2—Definitions—Permanent Disability.**

The Labor Code does not define "permanent disability." However, permanent disability is understood as the irreversible residual of an injury. Permanent disability payments are intended to compensate workers for both physical loss and the loss of some or all of their future **[*1537]** earning capacity. The right to permanent disability compensation does not arise until the injured worker's condition becomes permanent and stationary. The individual physical and mental abnormalities resulting from injury are referred to as factors of permanent disability. The individual factors taken together constitute the entire permanent disability.

CA(5) **(5) Workers' Compensation § 1—Plenary Power of Legislature—Reform of Statutory Scheme.**

The California Constitution confirms the Legislature's plenary power to create, and enforce a complete system of workers' compensation, by appropriate legislation (Cal. Const., art. XIV, § 4). In 2004, the Legislature exercised that power by enacting omnibus reform of the workers' compensation statutes. Sen. Bill No. 899 (2003–2004 Reg. Sess.) was an urgency measure designed to alleviate a perceived crisis in skyrocketing workers' compensation costs.

CA(6) **(6) Workers' Compensation § 106—Benefits Recoverable—By Employee—Permanent Disability—Apportionment Based on Causation—Application to All Causes—Legislative Intent.**

The plain language of the new statutory scheme for workers' compensation requires apportionment to each cause of a permanent disability, including each distinct industrial injury. This conclusion is compelled by (1) the plain language of current Lab. Code, §§ 4663 and 4664; (2) the repeal of Lab. Code, former § 4750; (3) the legislative history; and (4) the deference courts owe the Workers' Compensation Appeals Board's interpretation of workers' compensation statutes. Sections 4663 and 4664 do not support an argument that the Legislature only intended to protect employers from liability for permanent disability previously compensated or not caused by their employment. The Legislature's use of the phrase "the injury" in § 4664, subd. (a), necessarily implies that each distinct industrial injury must be separately compensated. Furthermore, the plain language of § 4663, subd. (a), makes clear that the focus is no longer on the permanent disability itself, but its causes. "Apportionment based on causation" is not naturally limited to apportionment to nonindustrial causes and previous permanent disability awards. Rather, "apportionment based on causation" must mean apportionment to all causes, including each distinct industrial injury. Had the Legislature intended to insulate certain causes from apportionment, it would have said so. This understanding is confirmed by the plain language of § 4663, subd. (c). Again, the Legislature required assessment of the approximate percentage of permanent disability caused by the direct result of injury and not injuries. The plain language of § 4663, subd. (c), read in conjunction with the rest of the statutory scheme, suggests the Legislature's intent to **[*1538]** require apportionment on an injury-by-injury basis, and no longer only for previous permanent disability. Because the Legislature's intent is ascertainable from the language of the new apportionment statutes and the legislative history, courts cannot rely on § 3202 to defeat that intent.

CA(7) **(7) Statutes § 21—Construction—Legislative Intent—Established Principles of Law.**

The Legislature does not intend to overthrow long-established principles of law unless such intention is clearly expressed or necessarily implied.

CA(8) **(8) Workers' Compensation § 127—Judicial Review—Deference.**

The Workers' Compensation Appeals Board's conclusion that Sen. Bill No. 899 (2003–2004 Reg. Sess.) superseded the doctrine of *Wilkinson v. Workers' Compensation Appeals Bd.* is not clearly erroneous and is entitled to deference.

CA(9) **(9) Workers' Compensation § 5—Construction of Statutes—Liberal—Legislative Intent.**

Lab. Code, § 3202, provides that the workers' compensation statutes shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment. However, § 3202 is a tool for resolving statutory ambiguity where it is not possible through other means to discern the Legislature's actual intent. Section 3202 cannot supplant the intent of the Legislature as expressed in a particular statute. If the Legislature's intent appears from the language and context of the relevant statutory provisions, then courts must effectuate that intent, even though the particular statutory language is contrary to the basic policy of the workers' compensation law.

CA(10) **(10) Workers' Compensation § 106—Benefits Recoverable—By Employee—Permanent Disability—Apportionment of Industrial Injuries—Separateness and Distinctiveness.**

The plain language of current Lab. Code, §§ 4663 and 4664, as well as the California Supreme Court, make clear that apportionment is required for each distinct industrial injury causing a permanent disability, regardless of the temporal occurrence of permanent disability or the injuries themselves. The only relevant inquiry is whether separate and distinct industrial injuries have been sustained. If so, then each injury must stand on its own.

CA(11) **(11) Workers' Compensation § 106—Benefits Recoverable—By Employee—Permanent Disability—Apportionment Based on Causation—Distinct Industrial Injuries.**

The doctrine of *Wilkinson v. [*1539] Workers' Compensation Appeals Bd.* is inconsistent with the apportionment reforms enacted by Sen. Bill No. 899 (2003–2004 Reg. Sess.). A system of apportionment based on causation requires that each distinct industrial injury be separately compensated based on its individual contribution to a permanent disability. There may be limited circumstances when the evaluating physician cannot parcel out, with reasonable medical probability, the approximate percentages to which each distinct industrial injury causally contributed to the employee's overall permanent disability. In such limited circumstances, when the employer has failed to meet its burden of proof, a combined award of permanent disability may still be justified (Lab. Code, § 4663, subd. (c)). Here, the Workers' Compensation Appeals Board properly granted an employee workers' compensation in two separate awards where an agreed medical examiner determined that two industrial injuries to the employee's neck each caused 31 percent permanent disability.

[Herlick, California Workers' Compensation Law (6th ed. 2008) ch. 6, § 6.16; Hanna, Cal. Law of Employee Injuries and Workers' Compensation Law (2008) ch. 8, § 8.07; 2 Witkin, Summary of Cal. Law (10th ed. 2005) Workers' Compensation, §§ 295, 296.]

Counsel: Law Offices of Timothy D. Timmons and Timothy D. Timmons for Petitioner.

Farrell Fraulob & Brown, Cheryl Brown; and William A. Herreras for California Applicants' Attorneys Association as Amicus Curiae on behalf of Petitioner.

No appearance by Respondent Workers' Compensation Appeals Board.

Law Offices of Carl Taber and Carl Taber for Respondent The Permanente Medical Group.

Law Offices of Saul Allweiss and Michael A. Marks for California Workers' Compensation Institute as Amicus Curiae on behalf of Respondent The Permanente Medical Group.

Raymond G. Fortner, Jr., County Counsel, Leah D. Davis, Assistant County Counsel, Derrick M. Au, Principal Deputy County Counsel, Jeffrey L. Scott, Deputy County Counsel, and Lin Lee, Associate County Counsel, as Amici Curiae for Respondents.

[*1540] Chernow & Lieb and Timothy C. Nelson for Zenith Insurance Co. as Amicus Curiae on behalf of Respondents.

Sedgwick Detert Moran & Arnold, Christina J. Imre and Michael M. Walsh for CalChamber as Amicus Curiae on behalf of Respondents.

Judges: Opinion by Haerle, J., with Kline, P. J., [***2] and Richman, J., concurring.

Opinion by: Haerle

Opinion

[**168] **HAERLE, J.**—Diane Benson (Benson) seeks review of the en banc opinion and decision after reconsideration of the Workers' Compensation Appeals Board (Board) that granted her a total of $ 49,210, in two separate awards, based on a determination that two [**169] industrial injuries to her neck each caused 31 percent permanent disability. Benson contends she is entitled to a single award of $ 67,016.25 because she suffers a combined permanent disability from both injuries of 62 percent. Having previously granted Benson's petition for a writ of review, we now affirm the decision of the Board.

I. FACTUAL AND PROCEDURAL BACKGROUND

Benson began work as a file clerk for respondent The Permanente Medical Group (Permanente) in April 1992. Benson's job required her to stand essentially all day, except for some brief periods of sitting, and it required repetitive neck and upper extremity motion. On June 3, 2003, she sustained an injury to her neck while reaching up over her head and pulling out a plastic bin to file a chart, at which point she felt a pain in her neck. The next day, she went to work, but her neck hurt even more. She was initially diagnosed with neck strain and [***3] put on light duty. On July 15, 2003, Benson was placed on temporary total disability and did not return to work thereafter. In November 2003, she filed an application for adjudication of claim alleging a specific injury on June 3, 2003. Benson eventually underwent a three-level fusion of the cervical spine.

On September 26, 2005, Benson was examined by Joseph Izzo, M.D., who was acting as an agreed medical examiner (AME). In his report, Dr. Izzo concluded that Benson had actually sustained two separate injuries to her neck—the specific injury on June 3, 2003, and a cumulative trauma injury through June 3, 2003. Dr. Izzo also concluded that Benson's injuries both became permanent and stationary on September 26, 2005. Dr. Izzo apportioned half of Benson's permanent disability to cumulative trauma through June 3, 2003, and half to the specific injury of June 3, 2003. [1] Dr. Izzo **[*1541]** concluded there was no basis for apportionment to nonindustrial factors. Benson later filed a second claim for the cumulative trauma injury.

It is undisputed that Benson's combined permanent disability rating is 62 percent, after adjustment for age and occupation. At trial before the workers' compensation judge (WCJ), Permanente argued that the 2004 workers' compensation reform legislation, enacted as Senate Bill No. 899 (2003–2004 Reg. Sess.), [2] abrogated *Wilkinson v. Workers' Comp. Appeals Bd.* (1977) 19 Cal.3d 491 [138 Cal. Rptr. 696, 564 P.2d 848] (*Wilkinson*) and necessitated two separate awards of 31 percent permanent disability. Benson urged that *Wilkinson* had survived Senate Bill No. 899 and argued for the imposition of a single award based on a combined rating of 62 percent permanent disability. The WCJ issued her findings and award, which applied *Wilkinson* and issued a single award of $ 67,016.25 based on the combined permanent disability rating.

Permanente filed a petition for [***5] reconsideration, which the Board granted. Thereafter, the Board issued an en banc opinion and decision after reconsideration, wherein a majority of the Board held that "the rule [**170] in *Wilkinson* is not consistent with the new requirement that apportionment be based on causation and, therefore, *Wilkinson* is no longer generally applicable. Rather, we now must determine and apportion to the cause of disability for each industrial injury." [3] Applying its holding, the Board concluded that "[b]ased upon the AME's determination that each of [Benson's] two injuries was equally responsible for her current level of permanent disability, she is entitled to receive a separate award of 31% permanent disability for each injury." The Board amended the WCJ's findings and award to provide for two **[*1542]** separate awards of $ 24,605 each, based on two separate ratings of 31 percent permanent disability. The Board's two awards entitle Benson to a total of $ 49,210, with each award payable at $ 185 per week for 133 weeks. The WCJ's combined award entitled Benson to a total of $ 67,016.25, payable at $ 185 per week for 362.25 weeks. The difference is caused by the nonlinear benefit schedule, which more generously [***6] compensates more severe disabilities. (*Brodie, supra*, 40 Cal.4th at p. 1321 & fn. 5; Lab. Code, § 4658 [number of weeks of indemnity increases in proportion to percentage of permanent disability].)

One [***7] commissioner dissented, arguing that Senate Bill No. 899 did not impact *Wilkinson* and, alternatively, that substantial evidence did not support a finding that any permanent disability was caused by Benson's cumulative injury. This petition for a writ of review followed.

II. DISCUSSION

Benson maintains that the Board erred by (1) holding that the repeal of Labor Code former section 4750 (repealed by Stats. 2004, ch. 34, § 37), [4] and enactment of new sections 4663 and 4664, abrogated the *Wilkinson* doctrine and/or (2) applying sections 4663 and 4664 to require apportionment between two simultaneous industrial injuries. [5] For the reasons discussed below, we conclude that Senate Bill No. 899 superseded the *Wilkinson* doctrine and that current sections *4663 and 4664 require apportionment to each distinct industrial injury causing a permanent disability.* [6]

[**171] A. *STANDARD OF REVIEW*

HN2 When a workers' compensation decision rests on the Board's erroneous interpretation of the law, the reviewing court will annul the decision. (*Save Mart Stores v. Workers' Comp. Appeals Bd.* (1992) 3 Cal.App.4th 720, 723 **[*1543]** [4 Cal. Rptr. 2d 597].) The Board's conclusions on questions of law are reviewed de novo. (*Barnes v. Workers' Comp. Appeals Bd.* (2000) 23 Cal.4th 679, 685 [97 Cal. Rptr. 2d 638, 2 P.3d 1180]; *Kuykendall v. Workers' Comp. Appeals Bd.* (2000) 79 Cal.App.4th 396, 402 [94 Cal. Rptr. 2d 130].) When the reviewing court is asked to interpret and apply a statute to undisputed facts, the review is [***9] de novo. (*Wright v. Beverly Fabrics, Inc.* (2002) 95 Cal.App.4th 346, 352 [115 Cal. Rptr. 2d 503].)

HN3 ***CA(1)*** **(1)** When interpreting a statute, the reviewing court's purpose is to effectuate the Legislature's intent. (*DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 387 [20 Cal. Rptr. 2d 523, 853 P.2d 978].) "In construing a statute, [the court's] first task is to look to the language of the statute itself. [Citation.] When the language is clear and there is no uncertainty as to the legislative intent, [the court should] look no further and simply enforce the statute according to its terms. [Citations.]" (*Id.* at pp. 387–388.) " ' "If possible, significance should be given to every word, phrase, sentence and part of an act in pursuance of the legislative purpose." [Citation.] ... "When used in a statute [words] must be construed in context, keeping in mind the nature and obvious purpose of the statute where they appear." [Citations.] Moreover, the various parts of a statutory enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole. [Citations.]' " (*Id.* at p. 388.)

CA(2) **(2)** If the statutory language is susceptible of more than one reasonable interpretation, the courts look to "extrinsic aids, [***10] including the ostensible objects to be achieved, the evils to be remedied, the legislative history, public policy, contemporaneous administrative construction, and the statutory scheme of which the statute is a part. [Citations.]" (*People v. Woodhead* (1987) 43 Cal.3d 1002, 1008 [239 Cal. Rptr. 656, 741 P.2d 154].) ***HN4*** "In interpreting the workers' compensation statutes, [the court] give[s] great weight to the construction of the [Board], unless it is clearly erroneous or unauthorized. [Citation.]" (*Honeywell v. Workers' Comp. Appeals Bd.* (2005) 35 Cal.4th 24, 34 [24 Cal. Rptr. 3d 179, 105 P.3d 544]; accord, *Brodie, supra,* 40 Cal.4th at p. 1331.) On the other hand, the workers' compensation statutes "shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment." (§ 3202.)

B. *INDUSTRIAL INJURY AND PERMANENT DISABILITY*

HN5 ***CA(3)*** **(3)** Section 3208 defines "injury" as "any injury or disease arising out of the employment ... ." Under section 3208.1 "[a]n injury may be either: (a) 'specific,' occurring as the result of one incident or exposure which causes **[*1544]** disability or need for medical treatment; or (b) 'cumulative,' [**172] occurring as repetitive mentally or physically traumatic activities [***11] extending over a period of time, the combined effect of which causes any disability or need for medical treatment. The date of a cumulative injury shall be the date determined under Section

5412." "[A] compensable injury is one which causes disability or need for medical treatments." (*Coca-Cola Bottling Co. v. Superior Court* (1991) 233 Cal.App.3d 1273, 1284 [285 Cal. Rptr. 183, 286 Cal. Rptr. 855].)

HN6 ***CA(4)*** **(4)** The Labor Code does not define "permanent disability." However, "'[p]ermanent disability is understood as "the irreversible residual of an injury."' [Citation.]" (*Brodie, supra*, 40 Cal.4th at p. 1320.) "[P]ermanent disability payments are intended to compensate workers for both physical loss and the loss of some or all of their future earning capacity. [Citations.]" (*Ibid.*) The administrative regulations provide: "A disability is considered permanent when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment." (Cal. Code Regs., tit. 8, § 10152; accord, *Department of Rehabilitation v. Workers' Comp. Appeals Bd.* (2003) 30 Cal.4th 1281, 1292 [135 Cal. Rptr. 2d 665, 70 P.3d 1076] ["'[T]he right to permanent disability compensation does [***12] not arise until the injured worker's condition becomes "permanent and stationary."'"].) "'The individual physical and mental abnormalities resulting from injury are referred to as "factors" of permanent disability. The individual factors taken together constitute the entire permanent disability.' (Cal. Workmen's Compensation Practice (Cont.Ed.Bar) § 17.13, pp. 537–538.)" (*Hegglin v. Workmen's Comp. App. Bd.* (1971) 4 Cal.3d 162, 171 [93 Cal. Rptr. 15, 480 P. 2d 967].)

C. THE BOARD WAS CORRECT IN CONCLUDING THAT WILKINSON WAS ABROGATED BY SENATE BILL NO. 899

HN7 ***CA(5)*** **(5)** The California Constitution confirms the Legislature's "plenary power ... to create, and enforce a complete system of workers' compensation, by appropriate legislation ... ." (Cal. Const., art. XIV, § 4.) In 2004, the Legislature exercised that power by enacting omnibus reform of the workers' compensation statutes. (*Brodie, supra*, 40 Cal.4th at p. 1323.) Senate Bill No. 899 was "an urgency measure designed to alleviate a perceived crisis in skyrocketing workers' compensation costs." (*Brodie, supra*, 40 Cal.4th at p. 1329; accord, Stats. 2004, ch. 34, § 49.) The question presented is whether the *Wilkinson* doctrine remains controlling despite the Legislature's enactment [***13] of Senate Bill No. 899. We start by examining apportionment law as it existed before Senate Bill No. 899 and then turn to the new statutory scheme.

[*1545]

Apportionment Law Before Senate Bill No. 899

Before the enactment of Senate Bill No. 899, apportionment was governed by former sections 4663, [7] 4750, [8] and 4750.5. [9] [**173] (*Marsh v. Workers' Comp. Appeals Bd.* (2005) 130 Cal.App.4th 906, 911–912 [30 Cal. Rptr. 3d 598] (*Marsh*).) " 'Two sections, 4750 and 4663, appl[ied] to antecedent injuries. [Former] [s]ection 4750 relieve[d] an employer from the burden of compensating an injured worker for disability attributable to a preexisting permanent disability or physical impairment. [Former] [s]ection 4663 [did] the same when an injured worker's disability [was] partially attributable to a preexisting disease or condition.' " (*Marsh, supra*, 130 Cal.App.4th at pp. 911–912.) Former section 4663 "left employers liable for any portion of a disability that would not have occurred but for the current industrial cause; if the disability arose in part from an interaction between an industrial cause and a nonindustrial cause, but the nonindustrial cause would not alone have given rise to a disability, no apportionment was to be allowed. [***14] [Citations.]" (*Brodie, supra*, 40 Cal.4th at p. 1326.) "[F]ormer section 4750 was interpreted as granting employees wide latitude to disprove apportionment based on prior permanent disability awards by demonstrating that they had substantially rehabilitated the injury. [Citation.]" (*Brodie, supra*, 40 Cal.4th at pp. 1326–1327.) Thus, "[b]efore the enactment of Sen. Bill 899, apportionment was 'concerned with the disability, not its cause or pathology.' [Citation.]" (*Marsh, supra*, 130 Cal.App.4th at p. 912; accord, *Brodie, supra*, 40 Cal.4th at p. 1326 [under old apportionment rules "courts properly rejected

apportionment of a single disability with multiple causes"].)

In *Wilkinson*, our Supreme Court interpreted former section 4750 and held that "whenever a worker ... sustains successive injuries to the same part of his body and these injuries become permanent at the same time, the worker is entitled to an award based on the combined disability." (*Wilkinson, supra*, 19 **[*1546]** Cal.3d at p. 494, citing *Bauer v. County of Los Angeles* (1969) 34 Cal.Comp.Cases 594.) In *Wilkinson*, the employee [***16] had injured both of his knees—first, in a fall on April 15, 1972, and then again on June 30, 1972. (19 Cal.3d at p. 494.) It was determined that both injuries arose out of and occurred in the course of employment and that both injuries became permanent at the same time. (*Id.* at pp. 494–495.) After deducting preexisting disability caused by nonindustrial injuries, the WCJ apportioned the combined remaining permanent disability of 30.5 percent between the two industrial injuries, rating each at 15.25 percent. (*Id.* at p. 495.) The WCJ awarded $ 3,587.50 for each injury, or a total of $ 7,175. (*Ibid.*)

Wilkinson sought reconsideration, arguing his entitlement to a total award of $ 8,662.50, based on a combined permanent disability rating of 30.5 percent for both injuries. (*Wilkinson, supra*, 19 Cal.3d at [**174] p. 496.) The Board upheld the WCJ's separate awards in reliance on former section 4750. (19 Cal.3d at p. 496.) Our Supreme Court disagreed, reasoning that former section 4750 did "not require apportionment in all cases of successive injuries, but only in cases of successive permanent disabilities. If the worker incurs successive injuries which become permanent *at the same time*, neither permanent disability [***17] is 'previous' to the other, and section 4750 hence does not require apportionment." (19 Cal.3d at p. 497.) The court noted that this understanding "also serves the practical purpose of avoiding the necessity for apportioning disability in a class of cases in which, *because of the nature and timing of the injuries, any apportionment is likely to be unsupported by* substantial evidence." (*Ibid.*) Thus, the court held that "the board erred in apportioning Wilkinson's permanent disability between the injuries of April 15, and June 30, 1972" and remanded with instructions to award benefits based on a combined permanent disability of 30.5 percent. (*Id.* at p. 502.)

The Board's Decision

In this case, the Board concluded, at Permanente's urging, that the Legislature's repeal of former section 4750 and enactment of new sections 4663 and 4664 revealed its plain intent to adopt a new apportionment scheme inconsistent with the *Wilkinson* doctrine. The Board's decision, and Permanente's argument before us, relies in large part on the plain language of new sections 4663 and 4664. Section 4664, subdivision (a), provides: ***HN8*** "The employer shall only be liable for the percentage of permanent disability directly caused [***18] by the injury arising out of and occurring in the course of employment." 10 Section 4663 provides, in relevant part, as follows:

[*1547]

"(a) ***HN9*** Apportionment of permanent disability shall be based on causation.

"(b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

"(c) In order for a physician's report to be considered complete on the issue of permanent disability, the report must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the [**175] physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the *permanent disability* [***19] *arising from the injury. The physician shall then consult with other* physicians or refer the employee to another physician from whom the employee is authorized to seek

treatment or evaluation in accordance with this division in order to make the final determination.

"(d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments."

The Board also relied on *Brodie, supra*, 40 Cal.4th 1313. In *Brodie*, the Supreme Court considered the impact of Senate Bill No. 899 on the following question: "When a worker suffers an industrial injury that results in permanent disability, how should the compensation owed based on the current level of permanent disability be discounted for either previous industrial injury or nonindustrial disabilities?" 11 (*Brodie*, at p. 1317.) In *Fuentes v. Workers' Comp. Appeals Bd.* (1976) 16 Cal.3d 1 [128 Cal. Rptr. 673, 547 P.2d 449] **[*1548]** (*Fuentes*), the court had previously held that "formula A" was the correct method for calculating an award when permanent disability could be partially attributed to nonindustrial causes. (*Brodie, supra*, 40 Cal.4th at pp. 1322–1323 [noting "formula A" also applied when permanent disability could be partially attributed to a previous permanent disability].) Under "formula A," the percentage of permanent disability attributable to a new injury is calculated [***21] by subtracting the old permanent disability rating from the new permanent disability rating and then consulting the benefits table for the award due that difference. (*Brodie, supra*, 40 Cal.4th at pp. 1321–1322; *Fuentes, supra*, 16 Cal.3d at p. 5.)

After reviewing the prior approach to apportionment, the *Brodie* court attributed the 2004 statutory revisions to the following goals: (1) reversal of the rule barring apportionment "if the disability arose in part from an interaction between an industrial cause and a nonindustrial cause, but the nonindustrial cause would not alone have given rise to a disability" and (2) reversal of the rule allowing "employees wide latitude to disprove apportionment based on prior permanent disability awards [***22] by demonstrating that they had substantially rehabilitated the injury. [Citation.]" 12 (*Brodie, supra*, 40 Cal.4th at pp. 1326–1327.) The *Brodie* court reasoned that former sections 4663 and 4750, "as interpreted by the courts, were inconsistent with the new regime of apportionment based on causation, as well as the conclusive presumption that previous permanent disability still existed for apportionment purposes. (§§ 4663, subd. (a), 4664, subds. (a), (b).) [**176] Former section 4750 required consideration of the new injury 'by itself and not in conjunction with or in relation to the previous disability or impairment' and further called for compensation for the later injury to be determined 'as though no prior disability or impairment had existed.' But under Senate Bill No. 899 ... , the new approach to apportionment is to look at the current disability and parcel out its causative sources—nonindustrial, prior industrial, current industrial—and decide the amount directly caused by the current industrial source. This approach requires thorough consideration of past injuries, not disregard of them. Thus, repeal of section 4750 was necessary to effect the Legislature's purposes in adopting [***23] a causation regime." (*Brodie, supra*, 40 Cal.4th at pp. 1327–1328, fn. omitted.)

The court observed: " '[w]e do not presume that the Legislature intends ... to overthrow long-established principles of law unless such intention is clearly expressed or necessarily implied.' [Citations.]" (*Brodie, supra*, 40 Cal.4th at p. 1325.) Given that the legislative goals just noted sufficiently **[*1549]** explained the reforms, the absence of legislative history regarding calculation, and that the plain language of the new statutes did not compel any particular method of calculation, the Supreme Court held that Senate Bill No. 899 had not superseded *Fuentes*. (*Brodie, supra*, 40 Cal.4th at pp. 1325–1332.)

CA(6) **(6)** Benson analogizes to *Brodie* and maintains that neither the plain language of the new apportionment scheme, nor its legislative history, suggests that the Legislature sought to abrogate the 30-year-old *Wilkinson* decision. We disagree and conclude that ***HN12*** the plain language [***24] of the new statutory scheme requires apportionment to each cause of a permanent disability, including each distinct industrial injury. This conclusion is compelled by (1) the plain language of current sections 4663 and 4664; (2) the repeal of former section 4750; (3) the legislative history; and (4) the deference we owe the Board's interpretation of workers' compensation statutes. (*Honeywell v. Workers' Comp. Appeals Bd., supra*, 35 Cal.4th at p. 34.) We address each point in turn.

(1) *The Plain Language of* Sections 4663 *and* 4664

HN13 Sections 4663 and 4664 do not support Benson's argument that the Legislature only intended to protect employers from liability for permanent disability previously compensated or not caused by their employment. In fact, the plain language of sections 4663 and 4664 compels apportionment here.

Section 4664, subdivision (a), provides: "The employer shall only be liable for the percentage of permanent disability directly caused by *the injury* arising out of and occurring in the course of employment." (Italics added.) The Legislature's use of the phrase "the injury" necessarily implies that each distinct industrial injury must be separately compensated. Adopting Benson's [***25] interpretation would ignore the Legislature's use of the singular form of "injury," rather than the plural. Although all 62 percent of Benson's permanent disability was directly caused by *injuries* arising out of and occurring in the course of Benson's employment with Permanente, each distinct industrial *injury* directly caused only half of that permanent disability.

Furthermore, section 4663, subdivision (a), provides that "[a]pportionment of permanent disability shall be based on causation." The plain language of section 4663, subdivision (a), makes clear that the focus [**177] is no longer on the permanent disability itself, but *its causes*. "Apportionment ... based on causation" is not naturally limited to apportionment to nonindustrial causes and previous permanent disability awards. Rather, "[a]pportionment ... based on causation" must mean apportionment to all causes, including each distinct industrial injury. Had the Legislature intended to insulate certain causes from apportionment, it would have said so.

[*1550]

Our understanding is confirmed by the plain language of section 4663, subdivision (c), which calls for a physician to make an apportionment determination "by finding what approximate [***26] percentage of the permanent disability *was caused by the direct result of injury arising out of and occurring in the course of employment* and what approximate percentage of the permanent disability *was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries*." (Italics added.) Again, the Legislature required assessment of the approximate percentage of permanent disability "caused by the direct result of *injury*" and not injuries. (§ 4663, subd. (c), italics added.) We agree with the Board majority that the plain language of section 4663, subdivision (c), read in conjunction with the rest of the statutory scheme, suggests the Legislature's intent to require apportionment on an injury-by-injury basis, and no longer only for "previous permanent disability." [13] (Compare § 4663, subd. (c) with former § 4750.) Although *Brodie* did not address the precise question presented here, the *Brodie* court's interpretation of Senate Bill No. 899 is consistent with the Board majority's understanding. (See *Brodie, supra*, 40 Cal.4th at p. 1328 ["the new approach to apportionment is to look at the current disability and parcel out its causative sources—nonindustrial, [***27] prior industrial, current industrial—and decide the amount directly caused by the current industrial source"].)

The clear change in the statutory language indicates an intent to invalidate *Wilkinson*. (See *Mosk v. Superior Court* (1979) 25 Cal.3d 474, 493 [159 Cal. Rptr. 494, 601 P.2d 1030] ["Generally, a substantial change in the language of a statute or constitutional provision by an amendment indicates an intention to change its meaning."]; *Brodie, supra*, 40 Cal.4th at p. 1332.) Reference to other subdivisions of sections 4663 and 4664 makes clear that the Legislature was cognizant of the distinction between successive permanent disabilities and successive injuries. (See § 4663, subd. (d) ["An employee who claims an industrial injury shall, upon request, disclose all *previous permanent disabilities* or physical impairments." (Italics added.)]; § 4664, subd. (b) ["If the applicant has received a *prior award of permanent disability*, it shall be conclusively presumed that the *prior permanent disability* exists at the time of any subsequent industrial injury." (Italics added.)].) [***28] The Legislature's focus, in section 4663, subdivision (c), on apportionment to other causative factors, "including prior industrial injuries," rather than prior permanent disabilities, must be accorded significance. [14]

[*1551]

[**178] It is unreasonable to contend, as Benson does, that the plain language of section 4663, subdivision (c), is consistent with the continued validity of *Wilkinson*. **15** The dissenting commissioner below similarly contended that "section 4663, subdivision (c), provides for the apportionment of disability to 'other factors *both before and subsequent* to the industrial injury' (emphasis added), but it does not provide for the apportionment of disability to causation by 'other factors' where those factors are caused by successive industrial injuries and are *concurrent with* the factors of disability caused by the first industrial injury. ... That is, to rephrase *Wilkinson*: if the worker incurs successive injuries which become permanent at the same time, none of the factors causing permanent disability is 'before or subsequent' to the others, and section 4663 hence does not require apportionment."

The problem with the dissenting commissioner's approach is that it rewrites the statute to require apportionment based on "what approximate percentage of the permanent disability was caused by other factors both before and subsequent to [the permanent disability caused by] the industrial injury ... ." (§ 4663, subd. (c).) In so doing, the dissent assumes that [***32] section 4663, subdivision (c), was intended to perpetuate the preexisting permanent disability rule. However, Senate Bill No. 899 could not have been intended to eliminate [**179] the "but for rule" with respect to permanent disability simultaneously caused by industrial and *nonindustrial* factors while, at the same time, perpetuating the preexisting disability rule for industrial injuries. (See *Brodie, supra*, 40 Cal.4th at pp. 1326–1327, 1331 ["In cases of apportionment for causation, however, the notion of a 'first' 30 percent and a 'second' 30 percent will frequently not apply. Where an industrial cause and nonindustrial cause simultaneously interact and are equally responsible for a 60 percent injury, there is no first 30 percent or second 30 percent."]; *E.L. Yeager Construction v. Workers' Comp. Appeals Bd.* (2006) 145 Cal.App.4th 922, 929 [52 Cal. Rptr. 3d 133] ["prior disability or evidence of modified work performance is no longer a prerequisite to apportionment"].) In order for the Board to comply with section 4664, subdivision (a), and distinguish permanent disability directly caused by the industrial injury from permanent disability *simultaneously* caused by nonindustrial factors, medical evidence, determining [***33] the percentages attributable to each, must be available. (See *Brodie, supra*, 40 Cal.4th at pp. 1327, 1331.) Benson's interpretation of section 4663, subdivision (c), would deprive the Board of a physician's apportionment determination when permanent disability is simultaneously caused by multiple factors, industrial or otherwise.

In conclusion, we agree with the Board majority that the plain language of section 4663, subdivision (c), read in conjunction with the statutory scheme as a whole, "specifically requires a physician to determine what percentage of disability *was caused by each industrial injury*, regardless of whether any particular industrial injury occurred before or after any other particular industrial injury or injuries." Given the plain language of the new statutory provisions, we agree with the Board that "[a]pplication of *Wilkinson*, and the concomitant merging of separate injuries into a single award of disability, is contrary to the reforms set in place by SB 899, which mandate that an employer cannot be held liable for any disability other than that directly caused by the industrial injury."

(2) *Repeal of Former Section 4750*

The repeal of former section 4750 buttresses [***34] our conclusion. (See *Wilkinson, supra*, 19 Cal.3d at p. 497 [former § 4750 "d[id] not require apportionment in all cases of successive injuries, but only in cases of successive permanent disabilities"].) As the Supreme Court stated in *Brodie*: "the new approach to apportionment is to look at the current disability and **[*1553]** parcel out its causative sources—nonindustrial, prior industrial, current industrial—and decide the amount directly caused by the current industrial source. This approach requires thorough consideration of past injuries, not disregard of them. Thus, repeal of section 4750 was necessary to effect the Legislature's purposes in adopting a causation regime." (*Brodie, supra*, 40 Cal.4th at p. 1328.)

CA(7) **(7)** Nonetheless, Benson urges us to follow the presumption, reiterated by the *Brodie* court, that ***HN14*** the Legislature does not intend " 'to overthrow long-established principles of law unless such intention is clearly expressed or necessarily implied.' " (*Brodie, supra*, 40 Cal.4th at p. 1325.) According to Benson, we should be even more cautious than the *Brodie* court in inferring intent to supersede long-standing precedent from the repeal of former section 4750, because *Wilkinson* was an

[***35] exception to the *Fuentes* doctrine. (*Wilkinson, supra*, 19 [**180] Cal.3d at p. 500 ["[O]ur decision in *Fuentes* explaining how to apportion disability for injuries falling *within* section 4750 is inapplicable to [the successive industrial injuries at issue here] which do *not* fall within the scope of that section."].) Therefore, if the Legislature, by repealing former section 4750, did not intend to abrogate *Fuentes*, in which the result was mandated by the express language of former section 4750 (*Fuentes, supra*, 16 Cal.3d at p. 6), then surely it did not intend to abrogate Supreme Court precedent that provided an exception predicated on the same statute.

Brodie is distinguishable. In *Brodie*, the Supreme Court concluded that, with respect to *Fuentes*, "nothing in current section 4663 or section 4664 expressly requires formulas A, B, C, modified C, or any other approach to calculating compensation. Nor does anything in the language implicitly do so." (*Brodie, supra*, 40 Cal.4th at p. 1325.) With respect to apportionment, however, we agree with the Board that "the Legislature has not been silent." As amicus curiae CWCI contends: "*The permanent and stationary date of successive injuries is* [now] *irrelevant, [***36] because the requirement of a preexisting disability to support apportionment no longer exists.*" The Legislature rejected the combination of distinct industrial injuries when it repealed former section 4750 and enacted sections 4663 and 4664. Accordingly, any presumption in favor of the continued validity of *Wilkinson* does not apply. (*Brodie, supra*, 40 Cal.4th at p. 1325.)

(3) Legislative History

"When the [statutory] language is clear and there is no uncertainty as to the legislative intent, we [are required to] look no further and simply enforce the statute according to its terms. [Citations.]" (*DuBois v. Workers' Comp. Appeals Bd., supra*, 5 Cal.4th at pp. 387–388.) Inasmuch as the plain language of the new apportionment scheme expresses a legislative intent to abrogate the ***[*1554]*** *Wilkinson* doctrine, we are required to go no further. But even if some ambiguity were to exist in the statutory language, our conclusion is reinforced by the legislative history. 16

[**181] Senate Bill No. 899 itself provides: "This act is an *urgency statute* necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are: [¶] In order to *provide relief to the state from the effects of the current workers' compensation crisis* at the earliest possible time, it is necessary for this act to take effect immediately." (Stats. 2004, ch. 34, § 49, italics added.) The perceived crisis that the Legislature sought to relieve was one caused by soaring workers' compensation costs. (See Stats. 2004, ch. 34, § 49; Assem. Com. on Insurance, Analysis of Sen. Bill No. 899 (2003–2004 Reg. Sess.) as proposed to be amended July 9, 2003, p. 3 [identifying "crisis" linked to "skyrocketing costs"]; Cal. Chamber of Commerce, Floor [***39] Alert regarding Sen. Bill No. 899 (2003–2004 Reg. Sess.) Apr. 15, 2004 ["[w]orkers' compensation costs for employers have skyrocketed 136% over the past four years, on average"].)

We cannot agree with Benson that the Legislature's sole intent was to combat rising premium rates caused by disturbances within the insurance sector. (See Assem. Com. on Insurance, Analysis of Sen. Bill No. 899 (2003–2004 Reg. Sess.) as proposed to be amended July 9, 2003, pp. 3–4 [attributing increased insurance premium rates to deregulation and investment losses in the insurance sector, as well as increasing costs of medical care].) Workers' compensation costs "ha[d] increased for a number of reasons." **[*1555]** (*Id.* at p. 3.) As discussed below, the Legislature repeatedly indicated its specific intent to reform apportionment rules to meet the overarching legislative goal of cost reduction.

As noted by the *Brodie* court, "Senate Bill No. 899 (2003–2004 Reg. Sess.) started out as a minor bill designed to change one aspect of workers' compensation wholly unrelated to apportionment. (See Sen. Com. on Labor and Industrial Relations, Analysis of Senate Bill No. 899 (2003–2004 Reg. Sess.) as amended Apr. 21, 2003.) It was but one [***40] of 20 different bills to reform workers' compensation passed out of the Senate or Assembly in 2003. (Sen. Rules Com., Off. of Sen. Floor Analyses, Rep. on Sen. Bill No. 899 (2003–2004 Reg. Sess.) as amended July 14, 2003, pp. 2–3.) Senate and Assembly leaders responded to this plethora of overlapping measures by submitting them to a joint conference to digest the bills and incorporate their provisions into a single omnibus reform

measure. (Assem. Com. on Insurance, Analysis of Sen. Bill No. 899 (2003–2004 Reg. Sess.) as proposed to be amended July 9, 2003, p. 6.)" (*Brodie, supra*, 40 Cal.4th at p. 1329, fn. 12.)

During the 2003–2004 regular legislative session, apportionment reform was originally proposed in Assembly Bill No. 1481, Assembly Bill No. 1579, and Senate Bill No. 714. But these bills proposed reforms that differ significantly from the reforms ultimately enacted. (See Stats. 2004, ch. 34, §§ 33–35, 37–38; Assem. Bill No. 1481 (2003–2004 Reg. Sess.) as introduced Feb. 21, 2003, pp. 3–4; Sen. Amend. to Sen. Bill No. 714 (2003–2004 Reg. Sess.) Apr. 21, 2003, p. 2; Sen. Amend. to Assem. Bill No. 1579 (2003–2004 Reg. Sess.) July 2, 2003, pp. 60–61.) For example, Assembly Bill [***41] No. 1481 proposed, in relevant part: "Section 5705.1 [be] added to the Labor Code, to read: [¶] 5705.1. (a) The burden of proof for the apportionment regarding [**182] permanent disability *under Sections 4663, 4750, and 4750.5* shall rest upon the defendant. In accordance with Section 3202.5, the defendant shall demonstrate by a preponderance of the evidence, and by reasonable medical probability, that absent the industrial injury, the injured worker had lost, as a consequence of a preexisting injury or illness, some capacity to perform the activity affected by the injury. [¶] (b) Notwithstanding any other provision of this code relating to workers' compensation benefits, including Section 4062.9, in denying apportionment the appeals board may not, in determining permanent disability, rely on any medical report that fails to fully address the issue of apportionment and fails to set forth the basis of the medical opinion. In denying apportionment, the appeals board may not rely on any medical report that fails to apportion *a previous injury or illness that has been the subject of a prior claim for damages* or that fails to provide a discussion of the medical processes by which a previously asserted [***42] injury or illness resolved without affecting bodily function." (Assem. Bill No. 1481 (2003–2004 Reg. Sess.) as introduced Feb. 21, 2003, pp. 3–4, italics added; **[*1556]** accord, Sen. Amend. to Sen. Bill No. 714 (2003–2004 Reg. Sess.) Apr. 21, 2003, p. 2; Sen. Amend. to Assem. Bill No. 1579 (2003–2004 Reg. Sess.) July 2, 2003, pp. 60–61.)

It was when Senate Bill No. 899 emerged from the conference committee that the proposed apportionment provisions first appeared in the current form. (Proposed Conf. Rep. No. 1 to Sen. Bill No. 899 (2003–2004 Reg. Sess.), as proposed Apr. 15, 2004, pp. 88–89, 91.) Although the legislative history does not provide any further clarification for the changes, we must conclude that the changes had significance. None of the precursor bills had proposed repeal of former sections 4663 and 4750. (See Assem. Bill No. 1481 (2003–2004 Reg. Sess.) as introduced Feb. 21, 2003; Sen. Amend. to Sen. Bill No. 714 (2003–2004 Reg. Sess.) Apr. 21, 2003; Sen. Amend. to Assem. Bill No. 1579 (2003–2004 Reg. Sess.) July 2, 2003.) Furthermore, all of these precursor bills proposed limiting the Board's reliance "on any medical report that fails to apportion *a previous injury or illness [***43] that has been the subject of a prior claim for damages* ... ." (Assem. Bill No. 1481 (2003–2004 Reg. Sess.) as introduced Feb. 21, 2003, pp. 3–4, italics added; accord, Sen. Amend. to Sen. Bill No. 714 (2003–2004 Reg. Sess.) Apr. 21, 2003, p. 2; Sen. Amend. to Assem. Bill No. 1579 (2003–2004 Reg. Sess.) July 2, 2003, p. 60.) By removing this limitation and requiring physicians to apportion to "prior industrial injuries" without limitation, it can be inferred that the Legislature intended to expand the *scope of apportionment to include prior industrial injuries that had not been the subject of prior* compensation. (Compare Assem. Bill No. 1481 (2003–2004 Reg. Sess.) as introduced Feb. 21, 2003, pp. 3–4 with § 4663, subd. (c).) Had the Legislature intended apportionment only for prior industrial injuries that had been the subject of previous awards, it would not have changed the proposed statutory language.

The legislative history also demonstrates a clear intent to wipe the slate clean of prior apportionment law and proceed under an entirely new causation regime. (See Legis. Counsel's Dig., Sen. Bill No. 899 (2003–2004 Reg. Sess.) Stats. 2004, ch. 34, Summary Dig., p. 7 ["This bill would [***44] repeal and recast [apportionment] provisions."]; Sen. Rules Com., Off. of Senate Floor Analyses, Conf. Rep. No. 1 on Sen. Bill No. 899 (2003–2004 Reg. Sess.) as amended Apr. 15, 2004, p. 7 ["17. Present law replaced by language that apportionment of permanent disability is based on [**183] causation."].) As the Supreme Court has stated, the legislative history of Senate Bill No. 899 "highlights the Legislature's intent to change how one *arrives* at the percentage disability for which an employer or insurer is liable ... ." (*Brodie, supra*, 40 Cal.4th at p. 1329.)

We cannot conceive that the Legislature would intend to "replace" or "repeal and recast" the rules of apportionment but still retain the *Wilkinson* **[*1557]** doctrine. The Legislature indicated no such exception in either the legislative history or the statutory language. Furthermore, we are not convinced that the absence of reference to *Wilkinson* by name in either the statutory language or the legislative history compels its survival. The Legislature may have on occasion explicitly mentioned

certain judicial decisions it sought to overrule. (See, e.g., former § 4750.5 ["The purpose of this section is to overrule the decision in *Jensen v. WCAB* [(1982)] 136 [***45] Cal.App.3d 1042 [186 Cal. Rptr. 570]." (Italics added, underscoring omitted.)].) But Benson cites no legal authority compelling the Legislature to do so. In fact, when the Legislature undertakes to amend a statute which has been the subject of judicial construction "it is presumed that the Legislature was fully cognizant of such construction, and when substantial changes are made in the statutory language it is usually inferred that the lawmakers intended to alter the law in those particulars affected by such changes. [Citations.]" (*Palos Verdes Faculty Assn. v. Palos Verdes Peninsula Unified Sch. Dist.* (1978) 21 Cal.3d 650, 659 [147 Cal. Rptr. 359, 580 P.2d 1155]; see also *People v. Mendoza* (2000) 23 Cal.4th 896, 916 [98 Cal. Rptr. 2d 431, 4 P.3d 265] [Legislature's repeal of prior statute "together with its enactment of a new statute on the same subject ... with significant differences in language, strongly suggests the Legislature intended to change the law"].) When the Legislature repealed former section 4750 and provided for apportionment to causative factors, "including prior industrial injuries," it demonstrated a clear intent to overrule *Wilkinson*. (See § 4663, subd. (c).)

In enacting Senate Bill No. 899, the Legislature made approximately 45 revisions to the workers' compensation statutes. (Stats. 2004, [***46] ch. 34, §§ 1–45.) It is little wonder that the Legislature did not mention *Wilkinson* by name in the midst of such extensive reform. Furthermore, it is undisputed that sections 4663 and 4664 abrogated the rehabilitation rule and the bar against apportionment to pathology. (*Brodie, supra*, 40 Cal.4th at pp. 1326–1327.) Yet, the Legislature did not refer to the judicial decisions that had established those long-standing rules. If the Legislature can abrogate those lines of authority without explicit reference, then surely it can do the same regarding *Wilkinson*.

The fact that both workers and employers were to benefit from Senate Bill No. 899 as a whole does not help us interpret the specific statutes at issue here. (See Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Sen. Bill No. 899 (2003–2004 Reg. Sess.) as amended July 14, 2003, pp. 1–2 ["While there is agreement among the parties that the system is in need of repair, what remains subject for debate is what the real systemic problems are and how best to address them without diminishing the arguably meager benefits injured workers receive in this state."].) Benson's reliance on the few provisions of Senate Bill [***47] No. 899 that expanded employee benefits is misplaced. (§§ 4658, subd. (d)(1) [increasing benefits for workers with 70 **[*1558]** percent or greater permanent disability], 4658, subd. (d)(2) [**184] [increasing benefits for disabled workers denied prompt return to work], 5402, subd. (c) [providing additional medical benefits].) The *Brodie* court aptly observed that these changes were all made in areas other than apportionment. (*Brodie, supra*, 40 Cal.4th at p. 1330, fn. 13.)

Benson does not cite any legislative history that both specifically relates to apportionment and supports her position. When it came to apportionment, the Legislature "included a requirement that doctors include apportionment discussions in their reports (§ 4663, subds. (b), (c)), a prohibition against avoiding apportionment by proving that a prior injury had been rehabilitated (§ 4664, subd. (b)), a cap on awards based on injuries to any one body part (§ 4664, subd. (c)(1)), and a reversal of the case-law-imposed prohibition against apportionment based on cause and corresponding expansion of the range of bases that would trigger apportionment (§ 4663, subd. (a))." (*Brodie, supra*, 40 Cal.4th at p. 1330, fn. 13.) Even if the statutory [***48] language were ambiguous, the legislative history shows a clear intent to abrogate the *Wilkinson* doctrine.

(4) *Deference to the Board's Interpretation*

CA(8) **(8)** Finally, our conclusions are consistent with the en banc Board's well-reasoned majority opinion. "[T]he ***HN15*** Board has extensive expertise in interpreting and applying the workers' compensation scheme. Consequently, we give weight to its interpretations of workers' compensation statutes unless they are clearly erroneous or unauthorized. [Citations.]" (*Brodie, supra*, 40 Cal.4th at p. 1331.) ***HN16*** The Board's conclusion, that Senate Bill No. 899 superseded the *Wilkinson* doctrine, is not clearly erroneous and is entitled to deference.

CA(9) **(9)** We are well aware that ***HN17*** section 3202 provides that the workers' compensation

statutes "shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment." However, "[s]ection 3202 is a tool for resolving statutory ambiguity where it is not possible through other means to discern the Legislature's actual intent." (*Brodie, supra*, 40 Cal.4th at p. 1332.) Section 3202 "'cannot supplant the intent of the Legislature as expressed in a [***49] particular statute.' (*Fuentes v. Workers' Comp. Appeals Bd.*[, *supra*,] 16 Cal.3d [at p.] 8 ... .) If the Legislature's intent appears from the language and context of the relevant statutory provisions, then we must effectuate that intent, 'even though the particular statutory language "is contrary to the basic policy of the [workers' compensation law]."' [Citation.]" (*Kopping v. Workers' Comp. Appeals Bd., supra*, 142 Cal.App.4th at p. 1106.) Because the Legislature's **[*1559]** intent is ascertainable from the language of the new apportionment statutes and the legislative history, we cannot rely on section 3202 to defeat that intent.

D. *THE BOARD DID NOT ERR IN ITS APPLICATION OF THE CURRENT APPORTIONMENT STATUTES*

Benson argues that even if the Legislature did intend to abrogate *Wilkinson*, the Board nevertheless erred in requiring apportionment on the facts of this case because all of her disability "was caused by *simultaneous* industrial injuries." (Italics added.) We disagree and conclude that the plain language of the apportionment [**185] statutes (§§ 4663 & 4664) compels two separate awards here.

CA(10) **(10)** Benson maintains that section 4663, subdivision (c), does not mandate separate awards because neither [***50] of her injuries occurred before, or after, the other. But, as detailed above, ***HN18*** the plain language of current sections 4663 and 4664, as well as the Supreme Court's holding in *Brodie*, make clear that apportionment is required for each distinct industrial injury causing a permanent disability, regardless of the temporal occurrence of permanent disability or the injuries themselves. We agree with amicus curiae Zenith that the only relevant inquiry is whether separate and distinct industrial injuries have been sustained. [17] If so, "then each injury must stand on its own."

Because timing is no longer determinative, it is irrelevant that, as Benson contends, a cumulative injury does not "occur" until the cumulative effects of the trauma cause any disability or need for medical treatment. [18] Accordingly, Benson's reliance on *Norton v. Workers' Comp. Appeals Bd.* (1980) 111 Cal.App.3d 618 [169 Cal. Rptr. 33] is misplaced. [19]

In any event, we cannot agree that Benson's two industrial injuries were simultaneous or concurrent. Dr. Izzo never opined that Benson's cumulative injury and specific injury occurred simultaneously. In fact, Dr. Izzo stated his opinion that "50 percent of [Benson's] current permanent partial disability is apportioned to cumulative trauma through June 3, 2003," and that "50 percent is apportioned to the specific injury of June 3, 2003." (Italics added.) Dr. Izzo also observed that the cumulative trauma injury represented "degenerative changes in [Benson's] neck that created the spinal stenosis [and] **[*1560]** would obviously have to come about *over time*." (Italics added.) Thus, the medical evidence in this case in fact contradicts Benson's theory. Furthermore, section 3208.1 provides, in relevant part: "[a]n injury may be either: (a) 'specific,' *occurring as the result of one incident* or exposure which causes [***52] disability or need for medical treatment; or (b) 'cumulative,' *occurring as repetitive mentally or physically traumatic activities extending over a period of time*, the combined effect of which causes any disability or need for medical treatment." (Italics added.) Thus, by definition, cumulative and specific injuries do not occur simultaneously.

It is undisputed that Benson suffered a specific neck injury on June 3, 2003, and a cumulative neck injury through June 3, 2003. The Board properly made no findings regarding the temporal relationship of Benson's injuries because such an inquiry is now irrelevant. We conclude that the Board properly applied the new statutory scheme to require apportionment to Benson's two distinct industrial injuries, each of which caused half of Benson's permanent disability. [20]

[**186] E. *CONCLUSION*

CA(11) **(11)** We hold that *HN19* the *Wilkinson* doctrine is inconsistent with the apportionment reforms enacted by Senate Bill No. 899. We agree with the Board that a system of apportionment based on causation [***53] requires that each distinct industrial injury be separately compensated based on its individual contribution to a permanent disability. We also agree that there may be limited circumstances, not present here, when the evaluating physician cannot parcel out, with reasonable medical probability, the approximate percentages to which each distinct industrial injury causally contributed to the employee's overall permanent disability. In such limited circumstances, when the employer has failed to meet its burden of proof, a combined award of permanent disability may still be justified. (See § 4663, subd. (c); *Kopping v. Workers' Comp. Appeals Bd., supra*, 142 Cal.App.4th at p. 1115 ["the burden of proving apportionment falls on the employer because it is the employer that benefits from apportionment"].)

However, we do not face that situation here. The Board properly made two awards of 31 percent permanent disability each, based on Dr. Izzo's opinion that Benson's permanent partial disability was equally caused by "cumulative trauma *through* June 3, 2003" and "the specific injury of June 3, 2003."

[*1561]

III. DISPOSITION

The Board's opinion and decision after reconsideration is affirmed. The parties shall [***54] bear their own costs.

Kline, P. J., and Richman, J., concurred.

Petitoner's petition for review by the Supreme Court was denied April 29, 2009, S171408. Werdegar, J., did not participate therein.

Footnotes

1 *HN1* "'Apportionment is the process employed ... to segregate the residuals of an industrial injury from those attributable to other industrial injuries, or to nonindustrial [***4] factors, in order to fairly allocate the legal responsibility.' [Citation.]" (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1321 [57 Cal. Rptr. 3d 644, 156 P.3d 1100] (*Brodie*).)

2 Hereafter Senate Bill No. 899. In relevant part, Senate Bill No. 899 repealed Labor Code former sections 4663, 4750, and 4750.5 and added new Labor Code sections 4663 and 4664. (Stats. 2004, ch. 34, §§ 33–35, 37–38.)

3 The majority opinion noted that a single award may still be appropriate in certain circumstances: "We observe, however, that there may be limited circumstances, not present here, where the evaluating physicians cannot parcel out, with reasonable medical probability, the approximate percentages to which each successive injury causally contributed to the employee's overall permanent disability. Under these limited circumstances, a combined award of permanent disability may still be justified." "In such an instance, the physician's apportionment 'determination,' within the meaning of [Labor Code] section 4663, could properly be that the approximate percentages of disability caused by each of the successive injuries cannot reasonably be determined. As a result, the employee would be entitled to an undivided (i.e., joint and several) award for the combined permanent disability, because the respective defendants would have failed in their burdens of proof on the issue of apportionment. (*Kopping v. Workers' Comp. Appeals Bd.* (2006) 142 Cal.App.4th 1099, 1115 [48 Cal. Rptr. 3d 618].)"

4 All further statutory references are to the Labor Code unless otherwise indicated.

5 We requested and received supplemental briefing from the parties on the latter issue. In addition, the County of Los Angeles, Zenith Insurance Company (Zenith), and the California Chamber of Commerce (CalChamber) each filed amicus curiae briefs in support [***8] of Permanente on the latter issue. We also received amicus curiae briefs, on the *Wilkinson* issue, from the California Applicants' Attorneys Association (CAAA) and the California Workers' Compensation Institute (CWCI).

6 We reject Permanente's contention that Benson has forfeited review by failing to specifically allege a statutory ground for review under section 5952. Permanente's reliance on *In re S.B.* (2004) 32 Cal.4th 1287, 1293, footnote 2 [13 Cal. Rptr. 3d 786, 90 P.3d 746], is misplaced. *In re S.B.* held that a mother's failure to object to a juvenile court's visitation order did not bar the appellate court from entertaining her challenge to that order on appeal. (*Id.* at p. 1293.)

7 Former section 4663 (repealed by Stats. 2004, ch. 34, § 33) provided: "In case of aggravation of any disease existing prior to a compensable injury, compensation shall be allowed only for the proportion of the disability due to the aggravation of such prior disease which is reasonably attributed to the injury."

8 Former section 4750 (repealed by Stats. 2004, ch. 34, § 37) provided: "An employee who is suffering from a *previous permanent disability* or physical impairment and sustains permanent injury thereafter shall not receive [***15] from the employer compensation for the later injury in excess of the compensation allowed for such injury when considered by itself and not in conjunction with or in relation to the *previous disability* or impairment. [¶] The employer shall not be liable for compensation to such an employee for the combined disability, but only for that portion due to the later injury as though no prior disability or impairment had existed." (Italics added.)

9 Former section 4750.5 (repealed by Stats. 2004, ch. 34, § 38) provided, in relevant part: "An employee who has sustained a compensable injury and who subsequently sustains an unrelated noncompensable injury, shall not receive permanent disability indemnity for any permanent disability caused solely by the subsequent noncompensable injury."

10 Section 4664, subdivision (b), provides: ***HN10*** "If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof." The Third Appellate District has construed this provision to mean that once a permanent disability award has been made, the permanent disability so compensated will be conclusively presumed to exist and be subject to apportionment, unless the employer fails to prove overlap between the previous permanent disability and the new permanent disability caused by a subsequent industrial injury. (*Kopping v. Workers' Comp. Appeals Bd., supra*, 142 Cal.App.4th at p. 1114.) Thus, ***HN11*** section 4664, subdivision (b), [***20] "was intended to reverse the rule based on former section 4750 that permitted an injured employee to show rehabilitation of an injury for which a permanent disability award had already been issued [citations]." (*Brodie, supra*, 40 Cal.4th at p. 1327.)

11 In *Brodie*, the permanent disability level for each injured worker could be partially attributed to either (a) a prior industrial injury *that had resulted in a prior permanent disability award*; or (b) nonindustrial causes. (*Brodie, supra*, 40 Cal.4th at pp. 1318–1319.) In *Brodie*, no one argued, as Permanente does here, that apportionment was required when multiple industrial injuries had been suffered but no permanent disability previously awarded. (*Ibid.*)

12 We do not read this statement of legislative intent as determinative of the question presented here. (See *Chevron U.S.A., Inc. v. Workers' Comp. Appeals Bd.* (1999) 19 Cal.4th 1182, 1195 [81 Cal. Rptr. 2d 521, 969 P.2d 613] ["An opinion is not authority for propositions not considered."].)

13 Benson concedes that section 4663, subdivision (c), not only governs the physician's analysis, but also the Board's own apportionment determination.

14 The Third District Court of Appeal, in *Kopping v. Workers' Comp. Appeals Bd., supra*, 142 Cal.App.4th 1099, suggested a similar interpretation of section 4663, subdivision (c). In *Kopping*, the injured worker argued: " '[i]f the Legislature intended section 4664, subdivision (b)] to create a conclusive presumption requiring deduction of prior awards by operation of law, what would be the purpose of requiring physicians to calculate the percentage of current permanent disability caused by prior industrial injuries?' " (*Id.* at p. 1112.) The court responded: "One answer to that question is that section 4664(b) creates a presumption arising from 'a prior award of permanent disability,' not from a prior industrial injury. It is possible that an applicant may have had a prior industrial injury, *but never applied for or received an award of permanent disability* resulting from that injury. In such a case, in the event of a subsequent industrial injury, the presumption of section 4664(b) [***29] would have no effect, but a physician could still determine, as a matter of fact, that the applicant's present level of permanent disability was partially caused by the previous industrial injury." (*Ibid.*, italics added.)

15 Nor can we agree with CAAA that the Board's interpretation of Senate Bill No. [***30] 899 creates a speculative evidentiary standard. According to CAAA, "[i]f the injuries are such that the medical status of the injured worker is not stabilized in connection with each injury, it is impossible for a medical expert or trier of fact to determine the effect of one injury on another when the medical condition is fluid." (See *Wilkinson, supra*, 19 Cal.3d at p. 499 ["the interaction between the injuries may make apportionment of disability impossible or inequitable"].) CAAA's argument is better addressed to the Legislature. Section 4663, subdivision (c), provides, in part: "A physician *shall* make an apportionment determination by finding what approximate **[*1552]** percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors ... including *prior industrial injuries*." (Italics added.) The Legislature also explicitly provided that "[i]f the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the [***31] effect of that prior condition on the permanent disability arising from the injury.

The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination." (§ 4663, subd. (c).) Here, Dr. Izzo apparently had no difficulty in making an apportionment determination and did, in fact, apportion Benson's permanent disability between her two distinct industrial injuries. Benson does not argue that Dr. Izzo's opinion is speculative and we decline to address CAAA's argument to that effect. Because this argument was not raised by Benson in her petition, but only by amicus curiae, it is not properly before us. (*Pratt v. Coast Trucking, Inc.* (1964) 228 Cal.App.2d 139, 143 [39 Cal. Rptr. 332].)

16

Amicus curiae County of Los Angeles filed a request seeking judicial notice of: (1) a conference report of the Senate Rules Committee on Senate Bill No. 899; (2) a press release from the office of Governor Arnold Schwarzenegger after [***37] passage of Senate Bill No. 899; (3) an article written by David Neumark, for the Public Policy Institute of California, entitled *The Workers' Compensation Crisis in California* (Jan. 2005) California Economic Policy, page 1; and (4) minutes from the February 24, 2005, meeting of the Commission on Health and Safety and Workers' Compensation. Benson opposes the County of Los Angeles's request. We grant the County of Los Angeles's request for judicial notice with respect to item (1) above. "[I]t is well established that reports of legislative committees and commissions are part of a statute's legislative history and may be considered when the meaning of a statute is uncertain. [Citations.]" (*Hutnick v. United States Fidelity & Guaranty Co.* (1988) 47 Cal.3d 456, 465, fn. 7 [253 Cal. Rptr. 236, 763 P.2d 1326]; accord, *Kaufman & Broad Communities, Inc. v. Performance Plastering, Inc.* (2005) 133 Cal.App.4th 26, 31–32 [34 Cal. Rptr. 3d 520] (*Kaufman*).) However, we deny the County of Los Angeles's request for judicial notice with respect to items (2), (3), and (4) above. In construing a statute, "the court's task is to ascertain the intent of the Legislature as a whole in adopting a piece of legislation. [Citations.]" (*Quintano v. Mercury Casualty Co.* (1995) 11 Cal.4th 1049, 1062 [48 Cal. Rptr. 2d 1, 906 P.2d 1057] [***38] (*Quintano*).) Because there is no indication that the Legislature considered items (2), (3), or (4), they are not proper subjects of judicial notice. (*Cortez v. Purolator Air Filtration Products Co.* (2000) 23 Cal.4th 163, 168, fn. 2 [96 Cal. Rptr. 2d 518, 999 P.2d 706]; *Quintano, supra*, 11 Cal.4th at p. 1062, fn. 5; *Kaufman, supra*, 133 Cal.App.4th at pp. 38, 42.)

17

Benson does not argue that her two industrial injuries are not separate and distinct.

18

For the sake of clarity, we note that inquiring when disability or need for medical treatment manifests is different from inquiring when permanent and stationary status occurs. Benson, however, seems to [***51] confuse the two concepts.

19 Furthermore, *Norton* is distinguishable. The *Norton* court concluded that two cumulative injuries occurred concurrently, rather than, as here, a cumulative injury and a specific injury. (*Norton v. Workers' Comp. Appeals Bd., supra*, 111 Cal.App.3d at pp. 627–629.)

20 Accordingly, we need not consider the argument articulated by Permanente's supporting amici curiae that if Senate Bill No. 899 does not mandate apportionment here, then sections 3208.2 and 5303 do.

Content Type: Cases

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State Comp. Ins. Fund v. Workers' Comp. Appeals Bd., 201 Cal. App. 4th 443

Copy Citation

Reporter

201 Cal. App. 4th 443 * 133 Cal. Rptr. 3d 866 ** 2011 Cal. App. LEXIS 1507 *** 76 Cal. Comp. Cases 1138 ****

STATE COMPENSATION INSURANCE FUND, Petitioner, v. WORKERS' COMPENSATION APPEALS BOARD and JAMES DORSETT, Respondents.

Subsequent History: [***1] The Publication Status of this Document has been Changed by the Court from Unpublished to Published December 1, 2011.

Reported at State Compensation Insurance Fund v. Workers' Comp. Appeals Bd., 2011 Cal. App. LEXIS 1788 (Cal. App. 6th Dist., Nov. 10, 2011)

Review denied by State Compensation Insurance Fund v. Workers' Compensation Appeals Board & Dorsett (James), 2012 Cal. LEXIS 1234 (Cal., Feb. 1, 2012)

Prior History: W.C.A.B. Nos. ADJ584277 [STK 0187511], ADJ4288246 [SJO 254750]—WCJ Steven Tuan (SJO); W.C.A.B. Panel: Commissioners Brass, Cuneo, Moresi [*see* Dorsett v. A-Tek Glass

Centers, 2011 Cal. Wrk. Comp. P.D. LEXIS 68 (Appeals Board panel decision)]

Disposition: Petition for writ of review from a decision of the Workers' Compensation Appeals Board. Petition *granted*, petition for writ of review *issued*, and WCAB decision *annulled*, and matter *remanded*.

Core Terms

apportionment, permanent disability, disability, injuries, industrial injury, cumulative trauma, permanent, compensable, percentage of permanent disability, specific injury, approximate, workers' compensation, reconsideration, rating, industrial, causation, cervical, factors, surgery, spine, combined permanent disability, successive injuries, apportioned, sections, awards

Case Summary

Procedural Posture

Petitioner State Compensation Insurance Fund sought review of a decision of respondent California Workers' Compensation Appeals Board denying reconsideration of a workers' compensation judge's (WCJ's) determination, based in part on the opinion of an agreed medical evaluator (AME), that respondent employee sustained an overall combined permanent disability of 100 percent, that there was only one injury, and that there could be no apportionment.

Overview

The employee had sustained a specific injury to his cervical spine eleven years ago, while working for a previous employer, and later sustained a cumulative trauma injury to his cervical spine while working for a different employer. The court observed that successive injuries to the same body part that become permanent and stationary at the same time could no longer be rated as a single injury. Rather, successive injuries had to be rated separately, except when physicians could not parcel out the causation of disability. The AME stated that the employee's two injuries became permanent and stationary at the same time and that his current level of permanent disability—whatever that level might be—was apportioned 50 percent to the specific injury and 50 percent to the cumulative trauma injury. The doctor made a determination based on his medical expertise of the approximate percentage of permanent disability caused by the

employee's two injuries. Lab. Code, § 4663, subd. (c), required no more. Thus, based on the testimony of the AME, the successive injuries could be rated separately, and the employee's joint and several award of 100 percent permanent disability had to be annulled.

Outcome

The court annulled the order denying reconsideration and remanded the matter to the Board with directions to order the WCJ to make an apportionment determination by finding what approximate percentage of the employee's permanent disability was caused by the direct result of the cumulative trauma injury and what approximate percentage of the permanent disability was caused by other factors, including his prior specific industrial injury.

▼ LexisNexis® Headnotes

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards > Types of Awards

HN1 **Benefit Determinations, Cumulative & Successive Disabilities**
See Lab. Code, § 4663. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards > Types of Awards

HN2 **Benefit Determinations, Cumulative & Successive Disabilities**
See Lab. Code, § 4664. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > >

Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards > >

Types of Awards

HN3 **Benefit Determinations, Cumulative & Successive Disabilities**
Employers must compensate injured workers only for that portion of their permanent disability attributable to a current industrial injury, not for that portion attributable to previous injuries or to nonindustrial factors. Apportionment is the process employed by the California Workers' Compensation Appeals Board to segregate the residuals of an industrial injury from those attributable to other industrial injuries, or to nonindustrial factors, in order to fairly allocate the legal responsibility. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > >

Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards > >

Types of Awards

HN4 **Benefit Determinations, Cumulative & Successive Disabilities**
Apportionment is based on causation. Lab. Code, § 4663, subd. (a). Under Sen. Bill No. 899 (2003-2004 Reg. Sess.), the new approach to apportionment is to look at the current disability and parcel out its causative sources—nonindustrial, prior industrial, current industrial—and decide the amount directly caused by the current industrial source. This approach requires thorough consideration of past injuries, not disregard of them. The clear intent of the legislature in enacting Sen. Bill No. 899 was to charge employers only with that percentage of permanent disability directly caused by the current industrial injury. Therefore, evaluating physicians, the workers' compensation judge, and the California Workers' Compensation Appeals Board must make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. § 4663, subd. (c). More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > >

Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards >

Types of Awards

HN5 **Benefit Determinations, Cumulative & Successive Disabilities**
The plain language of Lab. Code, § 4663, subd. (c), read in conjunction with the statutory scheme as a whole, specifically requires a physician to determine what percentage of disability was caused by each industrial injury, regardless of whether any particular industrial injury occurred before or after any other particular industrial injury or injuries. There may be limited circumstances when the evaluating physician cannot parcel out, with reasonable medical probability, the approximate percentages to which each distinct industrial injury causally contributed to the employee's overall permanent disability. In such limited circumstances, when the employer has failed to meet its burden of proof, a combined award of permanent disability may be justified. § 4663, subd. (c). More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations >

Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Administrative Proceedings > Awards >

Types of Awards

HN6 **Benefit Determinations, Cumulative & Successive Disabilities**
The legislature's focus, in Lab. Code, § 4663, subd. (c), on apportionment to other causative factors, including prior industrial injuries, rather than prior permanent disabilities, must be accorded significance. When an injured employee has a prior industrial injury, but never received an award of permanent disability resulting from that injury, a physician can still determine, as a matter of fact, that the injured worker's present level of permanent disability was partially caused by the previous industrial injury. When that occurs, the merging of separate injuries into a single award of disability, is contrary to the reforms set in place by Sen. Bill No. 899 (2003-2004 Reg. Sess.), which mandate that an employer cannot be held liable for any disability other than that directly caused the by the industrial injury. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > ... > Judicial Review > Standards of Review >

General Overview

HN7 **Judicial Review, Standards of Review**
Lab. Code, § 5302, states that decisions and awards of the California Workers' Compensation Appeals Board shall be presumed to be reasonable and lawful. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

HN8 **Benefit Determinations, Cumulative & Successive Disabilities**
Successive injuries to the same body part that become permanent and stationary at the same time cannot be rated as a single injury. Rather, successive injuries must be rated separately, except when physicians cannot parcel out the causation of disability. More like this Headnote

Shepardize - Narrow by this Headnote

Governments > Courts > Authority to Adjudicate

Governments > Legislation > Interpretation

HN9 **Courts, Authority to Adjudicate**
Courts interpret the law; courts do not write the law. More like this Headnote

Shepardize - Narrow by this Headnote

Headnotes/Syllabus

Summary

CALIFORNIA OFFICIAL REPORTS SUMMARY

The Workers' Compensation Appeals Board denied reconsideration of a workers' compensation judge's (WCJ's) determination, based in part on the opinion of an agreed medical evaluator (AME), that an employee sustained an overall combined permanent disability of 100 percent, that there was only one injury, and that there could be no apportionment. The employee had sustained a specific injury to his cervical spine 11 years ago, while working for a previous employer, and later sustained a cumulative trauma injury to his cervical spine while working for a different employer.

The Court of Appeal annulled the order and remanded the matter to the Board with directions to order the WCJ to make an apportionment determination by finding what approximate percentage of the employee's permanent disability was caused by the direct result of the cumulative trauma injury and what approximate percentage of the permanent disability was caused by other factors, including his prior specific industrial injury. The court observed that successive injuries to the same body part that become permanent and stationary at the same time can no longer be rated as a single injury. Rather, successive injuries must be rated separately, except when physicians cannot parcel out the causation of disability. The AME stated that the employee's two injuries became permanent and stationary at the same time and that his current level of permanent disability—whatever that level might be—was apportioned 50 percent to the specific injury and 50 percent to the cumulative trauma injury. The doctor made a determination based on his medical expertise of the approximate percentage of permanent disability caused by the employee's two injuries. Lab. Code, § 4663, subd. (c), requires no more.

Therefore, based on the testimony of the AME, the successive injuries could be rated separately, and the employee's joint and several award of 100 **[*444]** percent permanent disability had to be annulled. (Opinion by Bamattre-Manoukian ▽, J., with Elia ▽, Acting P. J., and Duffy, J.,[*] concurring.)

Headnotes

CALIFORNIA OFFICIAL REPORTS HEADNOTES

CA(1) **(1) Workers' Compensation § 110—Benefits Recoverable—Prior Disabilities and Subsequent Injuries—Apportionment—Causation.**

Employers must compensate injured workers only for that portion of their permanent disability attributable to a current industrial injury, not for that portion attributable to previous injuries or to nonindustrial factors. Apportionment is the process employed by the Workers' Compensation Appeals Board to segregate the residuals of an industrial injury from those attributable to other industrial injuries, or to nonindustrial factors, in order to fairly allocate the legal responsibility. Apportionment is based on causation (Lab. Code, § 4663, subd. (a)). Under Sen. Bill No. 899 (2003–2004 Reg. Sess.), the approach to apportionment is to look at the current disability and parcel out its causative sources—nonindustrial, prior industrial, current industrial—and decide the amount directly caused by the current industrial source. This approach requires thorough consideration of past injuries, not disregard of them. The clear intent of the Legislature in enacting Sen. Bill No. 899 was to charge employers only with that percentage of permanent disability directly caused by the current industrial injury. Therefore, evaluating physicians, the workers' compensation judge, and the Workers' Compensation Appeals Board must make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries (§ 4663, subd. (c)).

CA(2) **(2) Workers' Compensation § 110—Benefits Recoverable—Prior Disabilities and Subsequent Injuries—Apportionment—Grounds for Combined Awards.**

The plain language of Lab. Code, § 4663, subd. (c), read in conjunction with the statutory scheme as a whole, specifically requires a physician to determine what percentage of disability was caused by each industrial injury, regardless of whether any particular industrial injury occurred before or after any other particular industrial injury or injuries. There may be limited circumstances when the evaluating physician cannot parcel out, with reasonable medical probability, the **[*445]** approximate percentages to which each distinct industrial injury causally contributed to the employee's overall permanent disability. In such limited circumstances, when the employer has failed to meet its burden of proof, a combined award of permanent disability may be justified (§ 4663, subd. (c)).

CA(3) **(3) Workers' Compensation § 110—Benefits Recoverable—Prior Disabilities**

and Subsequent Injuries—Apportionment—Causation.

The Legislature's focus, in Lab. Code, § 4663, subd. (c), on apportionment to other causative factors, including prior industrial injuries, rather than prior permanent disabilities, must be accorded significance. When an injured employee has a prior industrial injury, but never received an award of permanent disability resulting from that injury, a physician can still determine, as a matter of fact, that the injured worker's present level of permanent disability was partially caused by the previous industrial injury. When that occurs, the merging of separate injuries into a single award of disability, is contrary to the reforms set in place by Sen. Bill No. 899 (2003–2004 Reg. Sess.), which mandate that an employer cannot be held liable for any disability other than that directly caused the by the industrial injury.

CA(4) **(4) Workers' Compensation § 89—Workers' Compensation Appeals Board—Decisions and Awards—Presumptions.**

Lab. Code, § 5302, states that decisions and awards of the Workers' Compensation Appeals Board shall be presumed to be reasonable and lawful.

CA(5) **(5) Workers' Compensation § 110—Benefits Recoverable—Prior Disabilities and Subsequent Injuries—Separate Ratings.**

Successive injuries to the same body part that become permanent and stationary at the same time cannot be rated as a single injury. Rather, successive injuries must be rated separately, except when physicians cannot parcel out the causation of disability.

CA(6) **(6) Statutes § 20—Construction—Judicial Function.**

Courts interpret the law; courts do not write the law.

CA(7) **(7) Workers' Compensation § 110—Benefits Recoverable—Prior Disabilities and Subsequent Injuries—Apportionment—Determination of Agreed Medical Evaluator.**

In a case in which the agreed medical evaluator (AME) stated that an employee's two injuries became permanent and stationary at the same time and that his current level of permanent disability—whatever that level might be—was apportioned 50 percent to the specific injury and 50 percent to his cumulative trauma injury, the doctor made a determination based on his medical expertise of the **[*446]** approximate percentage of permanent disability caused by the employee's two injuries. Lab. Code, § 4663, subd. (c), requires no more. Therefore, based on the testimony of the AME, the successive injuries could be rated separately, and the employee's joint and several award of 100 percent permanent disability had to be annulled.

[Herlick, California Workers' Compensation Law (6th ed. 2011) ch. 7, § 7.46; Hanna, Cal. Law of

Employee Injuries and Workers' Compensation Law (2011) ch. 8, § 8.07; 2 Witkin, Summary of Cal. Law (10th ed. 2005) Workers' Compensation, § 296.]

▼ California Compensation Headnotes/Summary

Headnotes

Permanent Disability > Apportionment

Court of Appeal, annulling WCAB's order denying reconsideration of WCJ's award of 100-percent [**1139] permanent disability from specific and cumulative trauma injuries to same body part, held that applicant's specific injury and cumulative trauma injury must each be rated separately, when Court of Appeal found that applicant sustained specific injury to his cervical spine on 3/21/2000 and cumulative trauma injury to his cervical spine between 11/15/2002 and 6/8/2004, that, pursuant to post-SB 899** Labor Code §§ 4663 **and** 4664, ***Benson v. W.C.A.B.*** (2009) 170 Cal. App. 4th 1535, 89 Cal. Rptr. 3d 166, 74 Cal. Comp. Cases 113, **and** ***Brodie v. W.C.A.B.*** (2007) 40 Cal. 4th 1313, 57 Cal. Rptr. 3d 644, 156 P.3d 1110, 72 Cal. Comp. Cases 565, **successive injuries to same body part that become permanent and stationary at same time cannot be rated as single injury, except when physicians cannot parcel out causation of disability, that agreed medical evaluator stated that applicant's two injuries became permanent and stationary at same time and that his "current level of permanent disability—whatever that level may be—is apportioned 50 percent to the specific injury and 50 percent to the cumulative trauma injury," and that, therefore, applicant's successive injuries can be rated separately.**

[See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[2][a], [c], 8.06[5][d].]

Counsel: Charles S. Bentley ▽, Patricia A. Brown and David M. Gol for Petitioner.

No appearance for Respondent Workers' Compensation Appeals Board.

Butts & Johnson ▽, Karina Johnson and Arthur Johnson ▽ for Respondent James Dorsett.

Judges: Opinion by Bamattre-Manoukian ▽, J., with Elia ▽, Acting P. J., and Duffy ▽, J., concurring.

Opinion by: Bamattre-Manoukian, J. ▽

Opinion

[**867] **BAMATTRE-MANOUKIAN, J.**—Respondent James Dorsett sustained a specific injury to his cervical spine on March 21, 2000, while working for South Valley Glass, Inc. (South Valley Glass), and a cumulative trauma injury to his cervical spine between November 15, 2002, and June 8, 2004, while working for A-Tek Glass, Inc. (A-Tek). Both employers were insured for purposes of workers' compensation by petitioner State Compensation Insurance Fund (SCIF). Dorsett filed separate applications to obtain workers' compensation for his injuries. The workers' compensation judge (WCJ) determined, based in part [***2] on the opinion of an agreed medical evaluator (AME), that Dorsett sustained an "overall combined permanent disability [of] 100 percent," that "there is only one injury," and that "there can be no apportionment under *Benson*."[1] SCIF filed separate petitions for reconsideration on behalf of South Valley Glass and A-Tek. The Workers' Compensation Appeals Board (the Board) denied reconsideration.

In its timely petition for writ of review filed in this court, SCIF contends that the Board erred "when—despite the clear statutory command of Labor Code § 4663 and § 4664, and the decision in *Benson* ... , which interpreted **[*447]** the statutes—it determined that apportionment of permanent disability did not apply."[2] As we find that the WCJ must make an apportionment determination in this case, we will annul [**868] the Board's order and remand the matter for further proceedings.

[****1140]

BACKGROUND

On March 20, 2000, Dorsett sustained a specific injury to his cervical spine while working as a glazer for South Valley Glass. He underwent two cervical spine surgeries, including a discectomy and fusion, and returned [***3] to work as a glazer with a weight lifting restriction. From November 15, 2002, through June 8, 2004, he sustained a cumulative trauma injury to his cervical spine while working as a glazer for A-Tek. Both employers were insured for purposes of workers' compensation by SCIF. Dorsett filed separate applications for workers' compensation benefits for his injuries. (ADJ584277 (STK 0187511), ADJ4288246 (SJO 0254750).)

In a report dated June 5, 2009, Dr. Joseph Izzo, a neurosurgeon and the AME in the cumulative injury case, stated: "There is no question in my mind that had [Dorsett] not had the injury in March of 2000 and had he not had the subsequent surgery that was indicated as a result of that injury and had he not had the unfortunate result of the surgery with subsequent ongoing neck symptoms, the cumulative trauma activities would not be an issue. [¶] The reason for that is that there is absolutely no indication that any of the degenerative changes that were present in his neck ... were at all symptomatic. [¶] Furthermore, there is no indication on reviewing all the medical records in this case that they would have ever been symptomatic. [¶] The simple fact of the matter is that had [***4] the March 2000 injury not occurred, the cumulative trauma injury would not have occurred. In fact, from that point of view, one can very well view this injury (CT injury to June of 2004) as a compensable consequence of the specific injury. [¶] Again this is not my opinion simply based on supposition, but based on the absence of any medical records that would indicate that any of the activities he did subsequent to the March 2000 incident would have led to any symptoms whatsoever."

During his deposition on August 26, 2009, Dr. Izzo stated: "I've only tried to present today and in these reports my approach from a medical point of view in terms of how one consequence of cumulative trauma interrelates to the prior consequence of specific injury. And I'm fully aware—and it makes sense to me as a nonlegal person—that two injuries are two injuries, as you said [counsel]. See, you have a specific and you have a cumulative. There's **[*448]** no question about that. ... The only disagreement ... is the interrelationship between the two. And my basis for my opinion, it's based on what I see to be an anatomy or accurately the change in anatomy created by the initial injury and subsequent surgery. [¶] [***5] I mean if you look at causation of disability as it [is] now looked at following especially *Escobedo*,[3] ... the cause of the eventual final disability is going to be the initial injury of 2000, the surgery and the outcome of the surgery with the changes it occurred [*sic*], and the subsequent cumulative trauma injury. If the initial one doesn't happen, as I've already said, the second one can't happen because there's no indication medically that he would have had any disability in 2004 absent the first injury of 2000."

[****1141]

In the same deposition, counsel for SCIF asked Dr. Izzo whether he was saying that Dorsett's "current level of permanent disability—whatever that level may be—is apportioned 50 percent to the specific injury and 50 percent to the cumulative trauma injury." Dr. Izzo answered, [**869] "That's correct." "What I'm simply saying is that, because of the first injury occurred and the fusion had happened—and, again, I'm repeating myself—exposure to the same type of activities subsequent to that injury led to the eventual permanent partial disability. And without the first injury, it is medically probable that that would not [***6] have happened simply because, if he had not had alteration in his anatomy, there's no medical evidence to indicate that he couldn't have continued to go on and do the usual and customary work as a glazer."

Following a two-day hearing, the two cases were submitted for decision principally on the issues of permanent disability and apportionment between the two injuries. The WCJ filed a joint findings, award, and order on December 16, 2010. He found that Dorsett was permanent and stationary as of September 20, 2007, that "[t]he injuries resulted in permanent disability of 100 [percent] combined, and [that] the permanent disability caused by each is not reasonably capable of separation or apportionment from the combined permanent disability." In his opinion on decision, the WCJ stated that he found Dorsett's "overall combined permanent disability is 100 percent" "primarily rel[ying] upon ... Dr. Izzo's opinion that based on physical disabilities alone, [Dorsett] is totally disabled." The WCJ further stated: "As to apportionment between the two injuries, Dr. Izzo indicates that the 11/15/02 through 6/8/04 cumulative injury is a compensable consequence of the 3/21/00 injury at South Valley [***7] Glass. Though Dr. Izzo also indicates that he would apportion permanent disability equally between the two injuries, since he indicated that the cumulative injury is a compensable consequence of the first specific injury, in essence there is only one injury, with the specific and subsequent cumulative trauma injury being inextricably intertwined to the extent that there can be no apportionment under *Benson*. The award of **[*449]** permanent disability is therefore made joint and several against both the 3/21/00 and 11/15/02 through 6/8/04 dates of injury."

SCIF filed separate petitions for reconsideration on behalf of South Valley Glass and A-Tek. On behalf of South Valley Glass, SCIF contended that "[t]he WCJ should have awarded permanent disability based on apportionment between the two injuries because finding both employers jointly and severally liable was based on an incorrect application of the 'compensable consequence' theory."

On behalf of A-Tek, SCIF contended that "[a] cumulative trauma injury cannot be both a compensable consequence of an earlier injury and a second injury as well. An injury cannot be a compensable consequence of a prior injury to the same body [part]. If the cumulative [***8] trauma is a compensable consequence of the 2000 injury, issuing a joint award is error. [¶] [The] WCJ ... erred in finding that the specific and cumulative trauma injury are inextricably intertwined to the extent that there cannot be apportionment."

In his report and recommendation on the petitions, the WCJ stated that *Benson* did not apply in this case because "*Benson* dealt with two successive injuries that [****1142] were admittedly separate and distinct," and "[t]he AME in *Benson* (also Dr. Izzo) did not indicate there that one was a compensable consequence of the other." "Though there is discussion in his deposition ... of his opinion that each injury contributed equally to the disability ... Dr. Izzo did indicate that it did not negate the concept of the two being 'inextricably intertwined.' ... He also confirmed on further questioning ... that he considered the CT a compensable consequence of the specific as 'an injury that is a direct and [**870] natural occurrence of an earlier injury that would not have occurred absent the earlier injury.' " "As the two injury claims are inseparable as one being a compensable consequence of the other it is appropriate to make the award jointly against both [***9] SCIF defendants." The WCJ recommended that both petitions for reconsideration be denied.

The Board denied reconsideration, adopting and incorporating the WCJ's report.

DISCUSSION

In this court, SCIF contends that the Board erred when "it determined apportionment of permanent disability did not apply" in this case. SCIF argues that, because Dr. Izzo clearly found two injuries, and he was able to apportion the permanent disability between the two injuries, the WCJ erred under sections 4663 and 4664 in making a joint and several 100 percent permanent disability award against the two employers.

[*450]

Dorsett contends that SCIF's argument "does not consider the exception outlined in *Benson* ... and failed to consider that the AME found one injury to be a compensable consequence of the other, and thus the injuries are not in fact 'separate' or 'distinct.' " Dorsett argues that one injury can be a compensable consequence of another injury, and that the employers failed in their burden of proof on the issue of apportionment.

Section 4663 provides, in pertinent part, that "(a) *HN1* Apportionment of permanent disability shall be based on causation. [¶] (b) Any physician who prepares a report addressing the [***10] issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability. [¶] (c) ... [T]he report must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. ... [¶] (d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments."

Section 4664 provides, in pertinent part, that "(a) *HN2* The employer shall only be liable for the percentage of permanent disability directly caused by the injury [***11] [****1143] arising out of and occurring in the course of employment. [¶] (b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. ... [¶] (c) (1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime ... . [¶] ... [¶] (2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent."

HN3 *CA(1)* **(1)** "Employers must compensate injured workers only for that portion of their permanent disability attributable to a current industrial injury, not for that portion [**871] attributable to previous injuries or to nonindustrial factors. 'Apportionment is the process employed by the Board to segregate the residuals of an industrial injury from those attributable to other industrial injuries, or to nonindustrial factors, in order to fairly allocate the legal responsibility.' [Citation.]" (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1321 [57 Cal. Rptr. 3d 644, 156 P.3d 1100] [***12] (*Brodie*).)

[*451]

Sections 4663 and 4664 were enacted as part of Senate Bill No. 899 (2003–2004 Reg. Sess.) (Senate Bill 899), an omnibus bill to restructure California's workers' compensation system. Before the enactment of Senate Bill 899, the general rule was that "apportionment was 'concerned with the disability, not its cause or pathology.' [Citation.]" (*Marsh v. Workers' Comp. Appeals Bd.* (2005) 130 Cal.App.4th 906, 912 [30 Cal. Rptr. 3d 598] (*Marsh*); see also *Benson, supra*, 170 Cal.App.4th at pp. 1545, 1557.) "Apportionment based on causation was prohibited. [Citation.]" (*Brodie, supra*, 40 Cal.4th at p. 1326.) "This rule left employers liable for any portion of a disability that would not have occurred but for the current industrial cause ... ." (*Ibid.*) "[I]n case after case courts properly rejected apportionment of a single disability with multiple causes. [Citations.]" (*Ibid.*) And employees were granted "wide latitude to disprove apportionment based on prior permanent disability awards by demonstrating that they had substantially rehabilitated the injury. [Citation.]" (*Id.* at pp. 1326–1327.)

"The plain language of new sections 4663 and 4664 demonstrates they were intended to reverse these features" of the former workers' [***13] compensation system. (*Brodie, supra*, 40 Cal.4th at p. 1327.) ***HN4*** Apportionment is now "based on causation." (§ 4663, subd. (a).) Under Senate Bill 899, "the new approach to apportionment is to look at the current disability and parcel out its causative sources—nonindustrial, prior industrial, current industrial—and decide the amount directly caused by the current industrial source. This approach requires thorough consideration of past injuries, not disregard of them." (*Brodie, supra*, 40 Cal.4th at p. 1328.) The "clear intent" of the Legislature in enacting Senate Bill 899 was "to charge employers only with that percentage of permanent disability directly caused by the current industrial injury." (*Brodie, supra*, 40 Cal.4th at p. 1332; see also *Marsh, supra*, 130 Cal.App.4th at p. 912.) Therefore, evaluating physicians, the WCJ, and the Board must "make an apportionment determination by finding what approximate [****1144] percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial [***14] injuries." (§ 4663, subd. (c); see also *Benson, supra*, 170 Cal.App.4th at p. 1550, fn. 13.)

CA(2) **(2)** In *Wilkinson v. Workers' Comp. Appeals Bd.* (1977) 19 Cal.3d 491 [138 Cal. Rptr. 696, 564 P.2d 848], our Supreme Court held that "whenever a worker ... sustains successive injuries to the same part of his body and these injuries become permanent at the same time, the worker is entitled to an award based on the combined disability." (*Id.* at p. 494.) The *Wilkinson* court concluded that when two separate work-related injuries become permanent at the same time, neither permanent disability [**872] is previous to the other and the employee therefore is entitled to a single permanent disability rating. (*Id.* at **[*452]** p. 497.) However, the Court of Appeal in *Benson* concluded that "[t]he clear change in the statutory language" of sections 4663 and 4664 as a result of Senate Bill 899 indicates a legislative intent "to invalidate *Wilkinson*." (*Benson, supra*, 170 Cal.App.4th at p. 1550.) Now, ***HN5*** "the plain language of section 4663, subdivision (c), read in conjunction with the statutory scheme as a whole, 'specifically requires a physician to determine what percentage of disability *was caused by each industrial injury*, regardless of whether any particular industrial [***15] injury occurred before or after any other particular industrial injury or injuries.' " (*Benson, supra*, at p. 1552.)

"[T]here may be limited circumstances, not present here, when the evaluating physician cannot parcel out, with reasonable medical probability, the approximate percentages to which each distinct industrial injury causally contributed to the employee's overall permanent disability. In such limited circumstances, when the employer has failed to meet its burden of proof, a combined award of permanent disability may still be justified. (See § 4663, subd. (c); *Kopping v. Workers' Comp. Appeals Bd.*[(2006)] 142 Cal.App.4th [1099,] 1115 [48 Cal. Rptr. 3d 618] ['the burden of proving apportionment falls on the employer because it is the employer that benefits from apportionment'].)" (*Benson, supra*, 170 Cal.App.4th at p. 1560; see also *id.* at p. 1541, fn. 3.)

In *Benson*, an employee sustained a specific industrial injury to her neck on June 3, 2003. She eventually underwent surgical fusion of the cervical spine. In September 2005, Dr. Izzo, acting as an AME, concluded that the employee had actually sustained two separate injuries to her neck, the specific injury and a cumulative trauma injury through June [***16] 3, 2003, and that both injuries became permanent and stationary on the same date. Dr. Izzo apportioned half of the employee's permanent disability to the cumulative trauma injury and half to the specific injury. (*Benson, supra*, 170 Cal.App.4th at p. 1540.) The employee filed two separate claims for her injuries and it was undisputed that the employee's combined permanent disability rating as a result of her injuries was 62 percent. The WCJ issued the employee a single permanent disability award based on the combined permanent disability rating, rather than two separate awards of 31 percent permanent disability. (*Id.* at p. 1541.) The board granted the employer's [****1145] petition for reconsideration, and concluded, en banc, that " '[b]ased upon the AME's determination that each of [the employee's] two injuries was equally responsible for her current level of permanent disability, she is entitled to receive a separate award of 31% permanent disability for each injury.' " (*Ibid.*) The employee filed a petition for writ of review.

CA(3) **(3)** The appellate court held that "the plain language of sections 4663 and 4664 compels apportionment here." (*Benson, supra*, 170 Cal.App.4th at **[*453]** p. 1549.) ***HN6*** "The Legislature's focus, [***17] in section 4663, subdivision (c), on apportionment to other causative factors, 'including prior industrial injuries,' rather than prior permanent disabilities, must be accorded

significance." (*Id.* at p. 1550, fn. omitted.) When an injured employee has a prior industrial injury, but never received an award of permanent disability resulting from that injury, a physician could still determine, as a matter of fact, that the injured worker's present level of permanent disability was partially [**873] caused by the previous industrial injury. (*Id.* at pp. 1550–1551, fn. 14; see also *Kopping v. Workers' Comp. Appeals Bd., supra*, 142 Cal.App.4th at p. 1112.) When that occurs, the " 'merging of separate injuries into a single award of disability, is contrary to the reforms set in place by SB 899, which mandate that an employer cannot be held liable for any disability other than that directly caused the by the industrial injury.' " (*Benson, supra*, at p. 1552.) Accordingly, the appellate court concluded that "[t]he Board properly made two awards of 31 percent permanent disability each, based on Dr. Izzo's opinion that [the employee's] permanent partial disability was equally caused by 'cumulative trauma [***18] *through* June 3, 2003,' and 'the specific injury of June 3, 2003.' " (*Id.* at p. 1560.)

CA(4) **(4)** The WCJ and the Board in the case before us found that there could be no apportionment pursuant to *Benson* because here, unlike in *Benson*, the evaluating physician found that the second industrial injury was a compensable consequence of the first industrial injury. We disagree with the Board's finding.***HN7*** Section 5302 states that decisions and awards of the Board shall be presumed to be reasonable and lawful. ***CA(5)*** **(5)** However, pursuant to Senate Bill 899, *Brodie,* and *Benson*, ***HN8*** successive injuries to the same body part that become permanent and stationary at the same time can no longer be rated as a single injury. Rather, successive injuries must be rated separately, except when physicians cannot parcel out the causation of disability. Absent an ambiguity in the statutory scheme, we may not rely on section 5302's directive to extend the benefits awarded to the injured worker here. (*Brodie, supra*, 40 Cal.4th at p. 1332.) ***CA(6)*** **(6)** While the legislative policy set forth in Senate Bill 899 treats Dorsett less favorably than if he had sustained a single injury with the same level of disability, ***HN9*** "we interpret the law; we do not write it." (*Barr v. Workers' Comp. Appeals Bd.* (2008) 164 Cal.App.4th 173, 178 [78 Cal. Rptr. 3d 732].)

CA(7) **(7)** Here, [***19] the AME stated that Dorsett's two injuries became permanent and stationary at the same time and that his "current level of permanent disability—whatever that level may be—is apportioned 50 percent to the specific injury and 50 percent to the cumulative trauma injury." "The doctor made a determination based on his medical expertise of the approximate percentage of permanent disability caused by [the employee's two injuries]. Section 4663, subdivision (c), [****1146] requires no more." (*E.L. Yeager Construction v. Workers' Comp. Appeals Bd.* (2006) 145 Cal.App.4th 922, 930 [52 Cal. Rptr. 3d **[*454]** 133].) Therefore, based on the testimony of the AME, the successive injuries can be rated separately and Dorsett's joint and several award of 100 percent permanent disability must be annulled. Upon remand, the WCJ must make an apportionment determination by finding what approximate percentage of Dorsett's permanent disability was caused by the direct result of the cumulative trauma injury and what approximate percentage of the permanent disability was caused by other factors, including his prior specific industrial injury. (§ 4663, subd. (c).)

DISPOSITION

The order denying reconsideration is annulled, and the matter is remanded to the [***20] Board with directions to order the WCJ to make an award consistent with this opinion.

[**874] Elia ▽, Acting P. J., and Duffy ▽, J., * concurred.

The petition of respondent James Dorsett for review by the Supreme Court was denied February 1, 2012, S198796.

Footnotes

[*] Retired Associate Justice of the Court of Appeal, Sixth Appellate District, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.

[1] *Benson v. Workers' Comp. Appeals Bd.* (2009) 170 Cal.App.4th 1535 [89 Cal. Rptr. 3d 166] (*Benson*).

[2] All further statutory references are to the Labor Code.

[3] *Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604 (en banc).

[*] Retired Associate Justice of the Court of Appeal, Sixth Appellate District, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.

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Apportionment Re-Visited (City of Jackson v. WCAB) Hikida v. WCAB, Costco

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THE DOCTRINE OF APPORTIONMENT

Strict Legal Apportionment /Causation of Injury
&
Apportionment Of Liability As Between Co-Defendants

The following represents a summary of some of the most recent case decisions issued by the California Supreme Court, California Court of Appeal, and the Workers' Compensation Appeals Board, which the Editor believes will have significance in connection with the Law of Apportionment and the practice of Workers' Compensation Law. The summaries are only the Editor's interpretation, analysis, and legal opinion, and the reader is encouraged to review the original case decision in its entirety.

Practitioners should proceed with caution when citing to this panel decision and should also verify the subsequent history of the decision. WCAB panel decisions are citable authority, particularly on issues of contemporaneous administrative construction of statutory language [see Griffith v. WCAB (1989) 209 Cal. App. 3d 1260, 1264, fn. 2, 54 Cal. Comp. Cases 145]. However, WCAB panel decisions are not binding precedent, as are en banc decisions, on all other Appeals Board panels and workers' compensation judges [see Gee v. Workers' Comp. Appeals Bd. (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cases 236]. While WCAB panel decisions are not binding, the WCAB will consider these decisions to the extent that it finds their reasoning persuasive [see Guitron v. Santa Fe Extruders (2011) 76 Cal. Comp. Cases 228, fn. 7 (Appeals Board En Banc Opinion)]. Panel Decisions which are designated as "Significant" by the WCAB, while not binding in workers compensation proceedings, are intended to augment the body of binding appellate court and en banc decision and is limited to panel decisions involving (1) issue(s) of general interest to the workers' compensation community, especially a new or recurring issue about which there is little or no published case law; and (2) upon agreement en banc of all commissioners on the significance and importance of the issues presented and resulting decisions. (See Elliot v. WCAB (2010) 182 Cal.App. 4th 355, 361, fn. 3, 75 CCC 81; Larch v. WCAB (1999) 64 CCC 1098, 1099-1100 (writ denied).

I. Summary of the Law of Apportionment

A. Burden of Proof

It is the party which benefits from the affirmative on the issue which has the burden of proof. It is the defendant who benefits from establishing apportionment of disability to nonindustrial causation, therefor it is the defendant who has the BURDEN OF PROOF on the issue of apportionment. *(See, PULLMAN KELLOGG v. WORKERS' COMPENSATION APPEALS BOARD (MARTIN G. NORMAND), (1980, Supreme Court of California) 26 Cal. 3d 450; 605 P.2d 422; 161 Cal. Rptr. 783; 1980 Cal. LEXIS 143; 45 Cal. Comp. Cases 170)*

B. Apportionment of Liability vs. Strict Legal Apportionment of Causation of Disability

'APPORTIONMENT OF LIABILTY" is as between co-defendants and apportions the cost for benefits provided for successive injuries/periods of coverage as between co-defendants. 'Apportionment of Liability" as between co-defendants is an equitable apportionment based on the facts, and medical evidence focusing on the severity/impact of each injury and/or degree of injuries exposure during a given period where a CT injury is involved. Generally, the injury resulting in a period of acute care is also responsible for the TD during the period of acute care. (LC 5500.5)

'STRICT LEGAL APPORTIONMENT' is apportionment of Causation of Disability either between (1) non-industrial and industrial causation, or (2) successive industrial injuries under the Benson Doctrine. (LC 4663/64)

C. Strict Legal Apportionment

The basis for "Strict Legal Apportionment of Disability" is found within only two provisions of the Labor Code: LC 4663 (Apportionment to Causation) and 4664 (Apportionment to a Prior Award).

Labor Code 4663 -- APPORTIONMENT TO CAUSATION

Labor Code Section 4663 involves the substantial evidence test generally having the following elements: That the medical opinion establishing the presence of non-industrial causation be based on (1) a FULL, COMPLETE AND ACCURATE MEDICAL HISTORY with a PROPER DISAGNOSIS; (2) that the opinion be based on REASONABLE MEDICAL PROBABILITY given the doctor's education, training and experience and his understanding of the fact involved in the case or presented to him by way of a hypothetical; (3) that that opinion provide the RATIONALE, CONSIDERED, and REASONED ANALYSIS; CONNECT THE DOTS; EXPLAIN FULLY THE BASIS for the opinion. It has properly been said that satisfying the 'substantial evidence test' required to establish the existence of nonindustrial causation is a higher standard than establishing the actual percentage of apportionment to industrial, prior industrial, and nonindustrial causation. Simply stated, the existence of apportionment to non-industrial causation must meet the 'substantial evidence test', while the percentage allocated between industrial and non-industrial will be sufficient unless the opinion is found to be arbitrary, capricious, or without rationale basis.

Editor's comments: Apportionment to genetic predisposition, or predisposition due to age, gender, race, morbid obesity, diet, smoking or other RISK FACTORS is generally NOT a proper basis for apportionment to causation. Rather, the prudent physician will limit apportionment to nonindustrial PATHOLOGY which is NOT the result of the subject industrial injury but is a direct cause of the disability. RISK FACTORS are, however, relevant as part of the physician's analysis in supporting his opinion that the pathology was pre-existing and thus nonindustrial, and thererby satisfying the substantial evidence test necessary for establish valid legal apportionment to non-industrial causation.

But see, City Of Jackson v. WCAB (Rice), (3rd Appellate District) 11 Cal. App. 5th 109; 216 Cal. Rptr. 3d 911; 82 Cal. Comp. Cases 437; 2017 Cal. App. LEXIS 383; Questionable analysis holding that apportionment may properly be based on genetics/hereditability, i.e., apportionment based on pathology and asymptomatic prior conditions for which the worker has an inherited predisposition," and that "no relevant distinction between allowing apportionment based on a preexisting congenital/pathological condition and allowing apportionment based on a preexisting degenerative condition caused by heredity or genetics exist. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[1], [2][a], 8.06[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.40[2], [3], 7.41[3].

The Doctrine of 'DIRECT CAUSATION' provides that the employer is only liable for that portion of the disability ACTUALLY, SOLEY AND DIRECTLY CAUSED (EXCLUSIVELY) by the subject industrial injury. Further, apportionment to separate industrial injuries is excused only under **EXTREMELY "LIMITED CIRCUMSTANCES**," ie. when the evaluating physician cannot parse out, with reasonable medical probability, the approximate percentages to which each distinct industrial injury causally contributed to the employee's overall permanent disability. . . in that the injuries, facts involved and medical evidence are found to be **"inextricably intertwined"** so that the reporting physician is unable to satisfy the 'substantial evidence' requirement under the *Escobedo* analysis. *(Benson v. The Permanent Medical Group (2009, 1st Appellate Court)170 Cal. App.4th 1535, 74 CCC 113, 37 CWCR 27).* It is only where the successive industrial injuries, facts involved and medical evidence are "inextricably intertwined" that a single combined award of PD is proper.

'Causation of Disability' should not be confused with 'Causation of Injury'. 'Causation of Injury' is a threshold issue dealing with establishing the existence of an industrial injury and scope of liability primarily involving medical care and temporary disability. "Causation of Disability" is an issue only raised after the applicant has been determined to be P&S and is limited to 'strict legal apportionment of disability', ie. determining the cause of the impairment and resulting disability pursuant to Labor Code 4663/64.

Labor Code 4664 -- APPORTIONMENT TO A PRIOR AWARD

Labor Code 4664, APPORTIONMENT TO A PRIOR AWARD has the following elements: (1) PRIOR AWARD of permanent disability, either by F&A or Stipulation with Request for Award, not to include a C&R; (2) generally, that BOTH the prior award and subject claim be either Old Guideline Awards or AMA Awards; and (3) that the disability awarded under the prior award OVERLAP the disability under the subject claim in that it involves the same part or region of the body. Under 4664 apportionment it is the defendant who has the burden of proof on all elements including overlap. *Kopping v. WCAB (CHP) (2006 Court of Appeal, 3rd Appellate District)) 71 CCC 1229, 142 Cal.App. 4th 1099.*

D. Cumulative Trauma Injury and Apportionment of Liability as Between Co-Defendants

Apportionment of Liability as between co-defendants again applies the doctrine of "Substantial Evidence" but is a highbred of the elements of "strict legal apportionment" and "Date of CT Injury. Apportionment of liability starts with an

analysis to determine the Date of CT injury. Here the focus in on "injurious events, exposures or activities" and the documented consequence. Here the physician is expected through review of medical records, deposition transcripts, and review of job descriptions, to allocate liability among co-defendant who are either sharing the period of CT or are responsible for successive CT industrial injuries involving the same part of body. This analysis is factually dependent and requires the reporting physician to use in equal parts medical knowledge, factual/medical information, and common sense. The primary consideration by the evaluating physician should focus on the physical arduousness of the industrial activity, and/or the intensity/severity of the exposure/events/activities in addressing the allocation of liability for the subject injurious exposure/activity period or periods as between co-defendants. It is the evaluating physician's analysis that is the most important component to apportionment of liability as between co-defendants.

Elements in apportionment of liability as between co-defendants are as follows: The first step in the analysis is to determine the date of CT injury. The date of CT injury requires the concurrence of (1) an injurious industrial exposure, events or activities, which results in (2) Disability (generally TD or PD) and (3) applicant's knowledge or reason to know the existence of a cause and effect relationship between the disability and the injurious industrial exposure.

The second step is to ask the questions as follows: Did the last date of "injurious exposure" occur before or after the "Date of CT Injury". If the "injurious exposure" ended before than the "Date of CT injury", than liability would be on the carrier on the risk during the year ending with the ending of the "injurious activities/events/exposures". If the injurious exposure continued beyond 'Date of CT Injury' than liability as between co-defendants would be the year period ending upon "Date of CT Injury".

II. Apportionment Case Law

Escobedo v. WCAB (2004) 70 CCC 604 (En Banc Decision)

Applicant was a 61-year-old sales associate and retail sales clerk for Marshall's. Applicant sustained a twisting injury to left knee on 10/20/02, when she suddenly turned a corner at work. Applicant also claimed injury to right knee as a compensable consequence. Prior to enactment of SB 899 applicant and defendant had secured medical legal reports.

Defendant's QME apportioned 50% of applicant's condition to asymptomatic arthritis and disc disease. SB 899 became effective April 19, 2004 and allowed apportionment to "direct causation" and requires a physician to apportion a percentage of the disability to "other factors" (non-industrial and prior industrial factors) . A treating physician's report was secured after the MSC but served prior to trial. The treater disagreed with the defendant's QME on the issue of apportionment finding that the industrial injury had "lit up" the pre-existing arthritis and therefore the entirety of the disability was industrial.

At trial applicant testified to no disability, treatment, nor problems prior to the subject industrial injury. Although the applicant's treater had diagnosed the applicant with arthritis some ten years prior, he did not impose any work restrictions. The WCJ held that LC 4663/4664 post SB 899 required apportionment to the asymptomatic arthritis and followed the opinion of the defendant's QME, apportioning 50% to non-industrial preexisting pathology. The award resulted in a net loss to the applicant and a saving to the defendant of $29,550.01.

> *"(1) Section 4663(a)'s statement that the apportionment of PD shall be based on "causation" refers to the causation of the PD, not causation of the injury, and the analysis of the causal factors of PD for purposes of apportionment may be different from the analysis of the causal factors of the injury itself. . .(2) Section 4663(c) not only prescribes what determinations a reporting physician must make with respect to apportionment, it also prescribes what standards the WCAB must use in deciding apportionment; that is, both reporting physician and the WCAB must make determinations of what percentage of the permanent disability was directly caused by the industrial injury and what percentage was caused by other factors. . .Applicant has the burden of establishing the percentage of PD directly caused by the industrial injury, and the defendant has the burden of establishing the percentage of disability caused by other factors. . .[apportionment may be to pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusion] provided there is substantial medical evidence establishing that these other factors have caused permanent disability. . . the report many not be relied upon unless it also constitutes substantial evidence."*

On reconsideration, counsel for applicant argued that (1) SB 899 should not be applied retroactively; (2) apportionment to causation does not include apportionment to pre-existing pathology absent the existence of prior work disability or impairment; and that (3) the opinion of Defendant's QME lacked substantial evidence because it failed to explain how, or in what way the applicant would have sustained 50% of her disability absent the work injury.

By en banc decision, the Board held SB 899 as to apportionment applied retroactively, and apportionment to asymptomatic preexisting pathology was appropriate provided it was based on an opinion which constituted substantial

evidence based on reasonable medical probability. The Court also held that the applicant has the burden of establishing percentage of permanent disability directly caused by industrial injury, with defendant having the burden of establishing percentage of disability caused by other factors.

Vargas v. Atascadero State Hospital, SCIF (2006) 71 CCC 500, (En Banc).

Applicant sustained injury on 3/22/95 which resulted in an award by F&A on 1/21/98 of 67% with a finding of no valid legal apportionment pre SB-899. Applicant filed a timely Petition to Reopen. The issue before the Board was (1) whether LC 4663 post SB-899 is retroactively applicable and (2) may the court revisit apportionment under the new standard for the entire award on Petition to Reopen, or merely the increase in PD.

See also, Kien v. Episcopal Homes Foundation, (2006) 34 CWCR 228 (WCAB Panel Decision) which held that SB-899 provisions could not be applied retroactively to recalculate the level of PD or revisit issues of apportionment determined under prior Stipulated Award and also that apportionment to pre-existing arthritis was invalid where the arthritic joint had been replaced as reasonable and necessary treatment of the work injury.

By en banc decision, the Board upheld their prior holding in *Rio Linda Union School Dist. V. WCAB (Scheftner) 70 CCC 999* that 4663 post SB-899 applies retroactively. However, on a Petition to Re-Open, the new apportionment standard applies only to the increase in PD over that previously awarded.

Acme Steel vs. WCAB, (Borman)(2013 1st District Appellate District) 218 Cal.App.4th 1137, 78 CCC 751.

The applicant filed a claim for multiple parts of body and underwent AME examination by three separate doctors in the fields of orthopedics, neurology, and otolaryngology (Hearing Loss). The issue before the Court of Appeal was whether the opinion of the otolaryngologist, who determined the applicant to have a 100% loss of hearing which was 60% industrial and 40% non-industrial, could be rebutted by VR testimony establishing the applicant was 100% totally disabled. Also relevant on the issue of apportionment under the *Benson* decision was that the applicant had received a prior award of 22% relating to a prior claim. At trial, the applicant presented VR testimony that the applicant as a result of a combination of factors including hearing loss was unable to work and had a TOTAL diminished earning capacity. The applicant received a 100% award from the WCJ who noted that the applicant had through, VR testimony, rebutted the DFEC and established a 100% loss of earning capacity. Further, the WCJ found no apportionment under LC 4664 to the applicant's prior award prior to the subject CT claim since there was no evidence of loss of earnings. The WCAB upheld on reconsideration the decision of the WCJ.

". . .the clear intent of the Legislature in enacting SB899 was "to charge employers only with that percentage of permanent disability directly caused by the current industrial injury. Therefore, evaluating physicians, the WCJ, and the Board must make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. Indeed, apportionment is excused only under extremely "limited circumstances, . . .when the evaluating physician cannot parcel out, with reasonable medical probability, the approximate percentages to which each distinct industrial injury causally contributed to the employee's overall permanent disability. . ."

Editors Comments: The Acme Steel/ Borman decision simply put merely stands for the proposition that an employer is only liable for that portion of a PD award which is the direct and exclusive result of the industrial injury regardless of the theory for the award. The employer shall not be held liable for that portion which is caused by non-industrial causes.

The Court of Appeal relying on the decision of *Brodie v. WCAB 40 Cal.4th 1313* found reversible error with respect to the issue of apportionment. The Court wrote that the WCJ and WCAB must make a determination of the approximate percentage of PD which was the direct cause of the industrial injury. Apportionment must be based upon causation which requires that the causation of disability must parcel out its sources to include nonindustrial, prior industrial, and current industrial. Apportionment is excused only under extremely limited circumstances. The Court was also critical of the WCAB for failure to consider substantial medical evidence on the issue of apportionment. Last, the Court rejected the WCJ's finding that the lack of actual prior earnings justified a finding of no apportionment under either LC 4663 or 4664.

Warner Bros. Studio v. WCAB (Crocker) (2013) 78 CCC 1198 (Writ Denied)

Applicant sustained a specific injury to lumbar spine on 1/19/07 which was resolved via stipulation with request for award for zero permanent disability. The applicant subsequently filed a claim of CT injury for the period ending 1/7/08. The parties agreed to utilize Dr. Alex Angerman as an AME in orthopedic medicine. Dr. Angerman found the applicant to be

totally and permanently disabled, and initially apportioned the PD equally between the specific and CT injuries utilizing LC 4663, apportionment to causation. Subsequently at deposition on direct examination by the applicant's attorney, Dr. Angerman was asked to consider the fact that LC 4664(b) states that PD from a prior award shall be "conclusively presumed" to exist at the time of any subsequent injury. Based on that assertion Dr. Angerman found no apportionment to the prior 2007 injury noting the absence of natural progression, and pre-existing disability. The WCJ found for the applicant and awarded 100% PD.

Editor's Comments: Although a simplistic reading of this decision might suggest that LC 4664 prohibits apportionment greater that the amount awarded by a prior final award, and therefore LC 4663 (apportionment to causation) may not be used to apportion, a more careful reading would be that: The conclusive presumption of PD under a prior award pursuant to LC 4664 prevents apportionment greater than the prior award unless it is established that the increase in the prior award is due to the (1) natural progression of the condition/pathology of the prior award, and (2) that the progression is a cause of the WPI/disability; and (3) that the opinion on apportionment increasing the PD under a prior award constitutes substantial evidence under an Escobedo analysis. Where all three of the foregoing are satisfied this editor believes valid legal apportionment to causation under LC 4663 would properly exist.

The WCAB and Court of Appeal upheld the WCJ, but noted that additional evidence included the PQME and vocational expert all of whom found the applicant to be totally disabled due to the CT injury, and without evidence of any disability attributable to the 2007 specific injury.

Hikida v. WCAB, Costco (2nd Appellate District) 12 Cal. App. 5th 1249; 219 Cal. Rptr. 3d 654; 82 Cal. Comp. Cases 679; 2017 Cal. App. LEXIS 572

Applicant developed carpal tunnel after working for over a quarter century with Costco. During May of 2010 the applicant elected to proceed with carpal tunnel surgery. Following, and as a result of the surgery the applicant development CARPS. Applicant had no pre-existing history of CARPS. Although the AME apportioned the carpal tunnel as 10% nonindustrial, he found no apportionment of the CARPS as it was the direct result of the carpal tunnel surgery. The AME found that the applicant was totally disabled entirely due to the CARPS. The WCJ apportioned 10% of the disability to non-industrial causation. Applicant sought reconsideration.

The WCAB, in a split panel decision upheld the WCJ. However, the dissent argued that because the entirety of the total disability was the result of the industrial surgery, apportionment was not proper.

The Court of Appeal reversed the WCAB/WCJ holding that while disability resulting from the carpal tunnel appeared proper, apportionment of compensable consequence injuries may not be proper. Here the applicant developed CARPS as a result of the surgery, not the CT injury. The Court found that "Nothing in the 2004 legislation had any impact on the reasoning that has long supported the employer's responsibility to compensate for medical treatment and the consequences of medical treatment without apportionment."

"Under the changes wrought by the 2004 amendments, the disability arising from petitioner's carpal tunnel syndrome was apportionable between industrial and nonindustrial causes. However, petitioner's permanent total disability was caused not by her carpal tunnel condition, but by the CRPS resulting from the medical treatment her employer provided. The issue presented is whether an employer is responsible for both the medical treatment and any disability arising directly from unsuccessful medical intervention, without apportionment. For the reasons discussed below, we conclude it is. . . The long-standing rule that employers are responsible for all medical treatment necessitated in any part by an industrial injury, including new injuries resulting from that medical treatment, derived not from those statutes, but from (1) the concern that applying apportionment principles to medical care would delay and potentially prevent an injured employee from getting medical care, and (2) the fundamental proposition that workers' compensation should cover all claims between the employee and employer arising from work-related injuries, leaving no potential for an independent suit for negligence against the employer. Nothing in the 2004 legislation had any impact on the reasoning that has long supported the employer's responsibility to compensate for medical treatment and the consequences of medical treatment without apportionment."

Hikika v. WCAB, Costco (2nd Appellate District) 82 Cal. Comp. Cases at pgs. 685-90.

Editor's Comments: A careful reading of the Hikida decision might limit its application to medical treatment resulting in a "new condition/diagnosis". I believe that an aggravation and worsening of an existing condition/diagnosis due to medical treatment would justify apportionment. In Hikida if the surgery had merely produced a worsening of the PD associated with the carpal tunnel, apportionment would have been appropriate. In Hikida a completely new condition, CARPS, not previously present and solely the result of the surgery rendered the applicant totally disabled.

See also, County of Sac. v. WCAB (Chimeri) 75 CCC 159; Nilsen v. Vista Ford 2012 Cal.Wrk.Comp.P.D. LEXIS 528; Moran v. Dept. of youth Authority 2011 Cal.Wrk.Cop. P.D. Lexis 43; Steinkamp v. City of Concord 2006 Cal.Wrk.Comp. P.D. LEXIS 24

City Of Jackson v. WCAB (Rice), (3rd Appellate District) 11 Cal. App. 5th 109; 216 Cal. Rptr. 3d 911; 82 Cal. Comp. Cases 437; 2017 Cal. App. LEXIS 383

Applicant claimed CT injury for the period ending 4/22/09 to neck arising out of a four year of full time employment as a police officer. Applicant was 29 years old as of the last year of the pled CT. Before undergoing surgery the applicant under a QME examination. The QME found the applicant's condition was caused by (1) his work activities for the City; (2) his prior work activities; (3) his personal activities, including prior injuries and recreational activities; and (4) his personal history, in which category Blair included "heritability and genetics," [applicant's] "history of smoking," and "his diagnosis of lateral epicondylitis [commonly known as tennis elbow]." Dr. Blair apportioned each factor equally at 25 percent.

By supplemental report, the QME affirmed that she could state "to a reasonable degree of medical probability that genetics has played a role in Mr. Rice's injury," despite the fact that there is no way to test for genetic factors. To support her opinion apportioning genetic factor, the QME cited to the referenced medical studies. In the end the QME apportioned 49% to the applicants 'personnel history including genetic issues'. The WCJ found that the City had carried its burden of showing apportionment as to 49 percent attributable to genetic factors, and this is the determination at issue here. The Board reversed reasoning that "finding causation on applicant's 'genetics' opens the door to apportionment of disability to impermissible immutable factors. … Without proper apportionment to specific identifiable factors, and therefore the Board held that the opinion of the QME was not substantial medical evidence to justify apportioning 49% of applicant's disability to non-industrial factors."

The Court of Appeal reversed the WCAB, holding that disability may be apportioned to a genetic predisposition. In support the Court appeared to focus on whether the QME's report constituted substantial evidence writing that the report reflected, 'without speculation, that Rice's disability is the result of cervical radiculopathy and cervical degenerative disc disease. Her diagnosis

"In Kos v. WCAB (2008) 73 CCC 529 the worker developed back and hip pain while working as an office manager. She was diagnosed with "multilevel degenerative disease," and the medical evaluator found that the underlying degenerative disc disease was not caused by work activities, but that the worker's prolonged sitting at work "'lit up'" her preexisting disc disease. (Id. at pp. 530, 531.) The medical evaluator testified that the worker's "pre-existing genetic predisposition for degenerative disc disease would have contributed approximately 75 percent to her overall level of disability." (Id. at p. 531.) Nevertheless, the ALJ found no basis for apportioning the disability. (Id. at p. 532.) The Board granted reconsideration and rescinded the ALJ decision. (Id. at p. 532.) The Board stated that in degenerative disease cases, it is incorrect to conclude that the worker's permanent disability is necessarily entirely caused by the industrial injury without apportionment. (Id. at p. 533.) Thus, in Kos, the Board had no trouble apportioning disability where the degenerative disc disease was caused by a "pre-existing genetic predisposition." (Id. at p. 531.)". . .

In Escobedo, supra, 70 Cal.Comp.Cases at pages 608, 609, the ALJ apportioned 50 percent of the worker's knee injury to nonindustrial causation based on the medical evaluator's opinion that the worker suffered from "'"significant degenerative arthritis."'" The Board stated: "In this case, the issue is whether an apportionment of permanent disability can be made based on the preexisting arthritis in applicant's knees. Under pre-[Senate Bill No.] 899 [(2003–2004 Reg. Sess.)] apportionment law, there would have been a question of whether this would have constituted an impermissible apportionment to pathology or causative factors. [Citations.] Under [Senate Bill No.] 899 [(2003–2004 Reg. Sess.)], however, apportionment now can be based on non-industrial pathology, if it can be demonstrated by substantial medical evidence that the non-industrial pathology has caused permanent disability. [¶] ... [¶] ...

Thus, the preexisting disability may arise from any source—congenital, developmental, pathological, or traumatic." (Id. at pp. 617–619.) We perceive no relevant distinction between allowing apportionment based on a preexisting congenital or pathological condition and allowing apportionment based on a preexisting degenerative condition caused by heredity or genetics.. . . In Acme Steel v. Workers' Comp. Appeals Bd. (2013) 218 Cal.App.4th 1137, 1139 [160 Cal. Rptr. 3d 712], the medical examiner apportioned 40 percent of the worker's hearing loss to "'congenital degeneration'" of the cochlea. (Id. at p. 1139.)

The ALJ nevertheless refused to apportion the disability, and the Board denied the employer's petition for reconsideration. (Id.at pp. 1140–1141.) The Court of Appeal granted the employer's writ of review and remanded the matter to the Board, holding Labor Code sections 4663 and 4664 required apportionment for the nonindustrial cause due to congenital degeneration where substantial medical evidence showed 100 percent of the hearing loss could not be attributed to the industrial cumulative trauma. (Acme Steel, at pp. 1142–1143.) Again, we see no relevant distinction between apportionment for a preexisting disease that is congenital and degenerative, and apportionment for a preexisting degenerative disease caused by heredity or genetics.[3]

" "'Disability' as used in the workers' compensation context includes two elements: "(1) actual incapacity to perform the tasks usually encountered in one's employment and the wage loss resulting therefrom, and (2) physical impairment of the body that may or may not be incapacitating." (Allied Compensation Ins. Co. v. Industrial Acc. Com. (1963) 211 Cal.App.2d 821, 831 [27 Cal. Rptr. 918].) Permanent disability is "'"the irreversible residual of an injury,"'" and permanent disability payments are intended to compensate for physical loss and loss of earning capacity. (Brodie, supra, 40 Cal.4th at p. 1320.) Here, Dr. Blair identified Rice's disability as neck pain and left arm, hand, and shoulder pain, which prevented him from sitting for more than two hours per day, lifting more than 15 pounds, and any vibratory activities such as driving long distances. All of these activities were included in Rice's job description.

Rice's injury, on the other hand, was a cumulative injury, which Dr. Blair stated Rice acknowledged was not an exact or isolated injury, but which he believed was a consequence of repetitive motion primarily resulting from his employment. Thus, the injury was repetitive motion. Dr. Blair did not conclude, as the Board apparently determined, that the repetitive motion (the injury) was caused by genetics. Rather, Dr. Blair properly concluded that Rice's disability, i.e., his debilitating neck, arm, hand, and shoulder pain preventing him from performing his job activities, was caused only partially (17 percent) by his work activities, and was caused primarily (49 percent) by his genetics. Contrary to the Board's opinion, Dr. Blair did not apportion causation to injury rather than disability."

was based on medical history, physical examination, and diagnostic studies that included X-rays and MRI's (magnetic resonance imaging scans). She determined that 49 percent of his condition was caused by heredity, genomics, and other personal history factors. Her conclusion was based on medical studies that were cited in her report, in addition to an adequate medical history and examination. Dr. Blair's combined reports are more than sufficient to meet the standard of substantial medical evidence.' In the end the Court held that apportionment may properly be based on genetics/hereditability, i.e., apportionment based on pathology and asymptomatic prior conditions for which the worker has an inherited predisposition," and that "no relevant distinction between allowing apportionment based on a preexisting congenital/pathological condition and allowing apportionment based on a preexisting degenerative condition caused by heredity or genetics exist. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[1], [2][a], 8.06[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.40[2], [3], 7.41[3].

Editor's Comments: The Rice opinion is correct as to its conclusion, but fatally flawed as to the analysis. Simple put the WCAB was correct that the WCJ had improperly apportioned based on causation of injury not causation of disability. First, the careful reader of the Rice decision with note that the Court incorrected cited the Kos v. WCAB (2008) 73 CCC 529 for the concept of "lighting up" as a basis for apportionment of disability. The 'lighting up' doctrine is only applicable a causation of injury analysis post SB-899/1/1/15, and not causation of disability. While an industrial injury may 'light up' asystematic pathology to create disability, the concept of 'lighting up' is only relevant to establish industrial injury/causation of injury. It is then up the evaluating physician to apportion between the industrial event, activity, or exposure which 'lit up' the prior non-industrial and pre-existing pathology. The relevance of risk factors, (genetic predisposition in the Rice case), is to support that the pathology was pre-existing and not industrial caused. The Court of Appeal should have started, discussed and ended with the single sentence found in the Discussion, section II section: "Again, we see no relevant distinction between apportionment for a preexisting disease that is congenital and degenerative, and apportionment for a preexisting degenerative disease caused by heredity or genetics."

Pacific Compensation Insurance v. WCAB (Nilsen) 78 CCC 722

The WCJ awarded 100% PD without apportionment in spite of the fact that the applicant had pre-existing medical condition. The WCJ relied on the opinion of applicant's VR expert who opined that although the applicant has pre-existing medical conditions those condition did not cause a loss of earning capacity. The VR expert relied on the fact that the applicant had a long and well established annual earning history of $100,000 to $120,000. Defendant sought reconsideration.

The WCAB in upholding the WCJ discussed extensively the medical evidence rather than just relying on the opinion of the VR expert. The WCAB noted that the applicant has sustained a specific injury to spine and as a compensable consequence chronic pain syndrome which was treated with extensive narcotics. The WCAB highlighted that the PQME found that 100% of the chronic pain syndrome was industrial, that the psychiatrist supported that conclusion, and the orthopedist opined that the applicant's high usage of narcotics made it impossible for the applicant to return to the labor market. Last, no evidence existed supporting that the non-industrial pre-existing conditions caused any of the total loss of earning capacity. Therefore, the WCAB upheld the decision of the WCJ that the applicant's total loss of earning capacity was directly, solely and exclusively the result of the industrial injury.

City of Cathedral City v. WCAB 78 CCC 696 (Writ Denied)

Applicant sustained injuries on 3/18/09 and a CT ending on 3/18/09. The WCJ awarded separate rather than combined rating reflecting apportionment. However, the AME in internal medicine found the two injuries "inextricably intertwined" for the purpose of applying *Benson* and did not provide separate ratings for each date of injury. The orthopedic AME however apportioned 90/10%. A critical fact in this decision appears to be an intentional mischaracterization of the law by the defense attorney at the deposition of the AME advising the doctor that *Benson* and LC 4663 "requires an apportionment of disability between separate industrial injuries". The WCJ made separate awards of 65% and 23% rather than a single award of 74%.

"Editor's Comments: A correct statement of the law under the Benson decision is that where successive injuries occur the evaluating physician is required to address the issue of causation of disability. In addressing this issue the physician is required to apportion between separate and distinct causes provided the physician is able to do so within reasonable medical probability based upon (1) a full, complete and accurate medical history and a proper diagnosis; and (2) the opinion is expressed within reasonable medical probability based on the doctor's education, training and experience; and (3) he must provide his considered analysis, connect the dots, express the rationale supporting his opinion. Where, however, the injuries, and facts involved and medical evidence are "inextricably intertwined" so that the reporting physician is unable to satisfy the substantial evidence requirement under Benson, a single combined award of PD is proper.

The WCAB in reversing the WCJ and awarding a single PD award of 74% noted that the AME had expressly stated at deposition that he did not see a rationale for apportionment, the two cases were inextricably intertwined and therefore it was not possible to apportion between the two cases. While as a general rule, separate determinations of the PD resulting from each injury should be made, an exception exists where the reporting physician is unable to within reasonable medical probability, parcel out the degree to which the injuries contributed to the employee's overall PD. In that situation, a combined rating is appropriate. F&A of the WCJ reversed and a combined and single award of 74% PD issued.

Kopping v. WCAB (CHP) (2006 Court of Appeal, 3rd Appellate District)) 71 CCC 1229, 142 Cal.App. 4th 1099.

Applicant was a CHP officer who sustained injury to back in 1996. Applicant settled his 1996 injury stipulating to a 29% award. Applicant sustained a second injury to back in December 2002. Based upon the AME's opinion, the parties stipulated that the applicant present disability was 27%. The AME found no apportionment reasoning that the applicant had medically rehabilitated himself. SCIF argued that the conclusive presumption under 4664 requires no new award of PD to applicant. The WCJ agreed.

> *LC 4064 provides, ". . .if the applicant has received a prior award of PD, it shall be conclusively presumed that the prior PD exists at the time of any subsequent industrial injury. . .This presumption is a presumption affecting the burden of proof."*

The issue on reconsideration and before the Court of Appeal was the proper interpretation of LC 4664. The WCAB cited and discussed *Sanchez v County of LA (2005) 70 CCC 1440* and *Strong v. City & County of SF (2005)* which held that "when the employer has established the existence of any prior PD award. . .the PD underlying any such award is conclusively presumed to still exist. . .the applicant is not permitted to show medical rehabilitation from the disabling effects of the earlier industrial injury . . .the percentage of the earlier award shall be subtracted unless the applicant disproves overlap." Based thereon, the WCAB remanded the matter back to the WCJ for further hearing on the issue of overlap. Applicant sought review.

> *". . .Section 4664 is a presumption affecting the burden of proof because it affects the employer's burden of proving apportionment by conclusively establishing that the PD resulting from the previous industrial injury still exist at the time of the subsequent injury. Although the conclusive presumption thus affects the employer's burden of proving apportionment by conclusively establishing the continued existence of the prior disability, it does not completely carry that burden, because the employer still has to prove the overlap, if any, between the previous disability and the current disability . . . in order to establish that apportionment is appropriate. . .Instead, that presumption [under LC 4664] arises from the long-standing principle -- which remains valid – that the burden of proving apportionment falls on the employer because it is the employer that benefits from apportionment ."*
>
> *Kopping v. WCAB (CHP) (2006 Court of Appeal, 3rd Appellate District)) 71 CCC at pg. 1241*

On review, after a lengthy discussion, the Court of Appeal held 4664 no longer allows applicant to reduce apportionment of a prior award through "medical rehabilitation." Next, the Court held Defendant need first establish the existence of a prior award. Then, Defendant must also prove the existence of overlap as between the prior award and current disability resulting from the current injury." Next, the Court held Defendant need first establish the existence of a prior award. Then, Defendant must also prove the existence of overlap as between the prior award and current disability resulting from the current injury.

Welcher v. WCAB (2006, 3rd Appellate District) 142 Cal.App. 4th 818, 71 CCC 1087.

Applicant sustained CT through 3/01 to his right leg resulting in a below the knee amputation and a 71% level of PD. Applicant had a prior award for a 1990 specific injury to his right arm and leg rating 62.5%. *Welcher* was consolidated with three other cases each involving prior awards with subsequent injuries and resulting PD. The issue in each was the correct fashion for calculating the PD award.

> *See also Davis v. WCAB, and Torres v. WCAB (11/30/2006)(6th Appellate District)34 CWCR 320, in accord with Welcher et. al.*
>
> *See also, Erickson v. Southern California Permanente Medical (12/26/06) 71 CCC __, (En Banc Decision)which concluded that it is appropriate to defer the final determination of how to calculate compensation, with defendant obligated to pay permanent disability and attorney's fees based upon the undisputed portion of benefits owed under the award.*

The Court of Appeal did not follow the holdings in *Nabors 140 Cal.App.4th 217* and *Dykes 134 Cal.App.4th 1536* which held that dollars and not percentage of disability was the proper calculation of the award of disability after apportionment. Instead, the Court held that percentages of disability of the prior award should be subtracted from the subsequent injury and

then the difference in percentages converted to dollars for the award. It should be noted, neither *Welcher* nor *Brodie* are citable authority as both have been accepted for review by the Supreme Court.

Ramirez v. LA Sheriff's Department (2014) 2014 Cal.Wrk.Comp. P.D. LEXIS 362

Applicant sustained a CT injury to right knee, lumbar spine, left hip and hypertension during her employment as a Deputy Sheriff for the period ending July 12, 2006. Applicant received a stipulated award of 53% for this injury but subsequently reopened alleging new and further disability. The WCJ found an increase in PD to 65% less credits for payments made but without apportionment finding the opinion of the AME on apportionment did not constitute substantial evidence. Defendant sought reconsideration.

The WCAB first noted that although LC section 3213.2, (presumption of injury to low back caused by peace officer duty belt) does not contain an express "non-attribution" clause, which would prohibit the reduction of benefits to an injured worker due to prior existence, development or manifestation of a disease preceding an industrial injury, LC section 4663(e) does expressly exclude apportionment any disability related to a peace officer's low back injury caused by the wearing of a duty belt. Subpart (e) states that subparts (a) through (c) do not apply to "injuries or illnesses covered under section … 3213.2."

Recon denied.

> *". . .Labor Code section 4663 requires apportionment to pre-existing or non-industrial causes. However, subsection (e) of 4663 provides for awards of permanent disability without apportionment for enumerated classes of employees with presumed compensable injuries. Applicant falls within one of the categories. Applicant is a peace officer. Labor Code section 3213.2 provides for a presumption of spine injury for peace officers required to wear duty belts. Labor Code section 3213.2(a) states:*
>
> *In the case of a member of a police department of a city, county, or city and county, or a member of the sheriff's office of a county, or a peace officer employed by the Department of the California Highway Patrol, or a peace officer employed by the University of California, who has been employed for at least five years as a peace officer on a regular, full-time salary and has been required to wear a duty belt as a condition of employment, the term "injury," as used in this division, includes lower back impairments. The compensation that is awarded for lower back impairments shall include full hospital, surgical, medical treatment, disability indemnity, and death benefits as provided by the provisions of this division.*
>
> *This section does not contain an express "non-attribution" clause, which would normally prohibit the reduction of benefits to an injured worker due to prior existence, development or manifestation of a disease preceding an industrial injury. However, the non-attribution of an employee's disability is codified in the apportionment statute in Labor Code section 4663. Any disability related to a peace officer's low back injury caused by the wearing of a duty belt is specifically excluded from apportionment under Labor Code section 4663(e). Subpart (e) states that subparts (a) through (c) do not apply to "injuries or illnesses covered under section … 3213.2."*
> *See also, accord City of Irvine v. WCAB (2013) 2013 Cal. Wrk. Comp. LEXIS 7 (Writ Denied.)*

Dufresne v. Sutter Maternity & Surgery Center of Santa Cruz (2014) 2014 Cal.Wrk.Comp. P.D. LEXIS 710

Applicant was a registered nurse who sustained successive injuries to thoracic spine on 2/22/99, 4/7/04/ and CT ending 4/7/04. Additionally, applicant had prior nonindustrial injury and resulting surgeries to low back and neck. The applicant did settle with co-defendant via C&R that defendant's liability for injury to thoracic spine. The parties agreed to use AME's for both the physical and psychiatric injury. Dr. Fugimoto, who reported as the AME on the physical component authored numerous reports in addition to being deposed. In the end it was his opinion that due to "(1) a combination of her musculoskeletal injuries (i.e., chronic thoracic, cervical, and low back pain) and her psychiatric issues that preclude applicant from working in the open labor market; (2) her inability to return to the open labor market is 80% caused by the industrial injuries and 20% by the nonindustrial injuries; and (3) it is the "synergistic effect"

> *"It is true that apportionment of permanent disability has been held to be impermissible in cases where an industrial injury gives rise to a conclusive presumption of permanent total disability under section 4662. (E.g., City of Santa Clara v. Workers' Comp. Appeals Bd. (Sanchez) (2011) 76 Cal.Comp.Cases 799 (writ den.) (under § 4662(d), employee was conclusively presumed to be permanently totally disabled because he had sustained an "injury to the brain resulting in incurable mental incapacity or insanity"); Kaiser Foundation Hospitals v. Workers' Comp. Appeals Bd. (Dragomir-Tremoureux) (2006) 71 Cal.Comp.Cases 538 (writ den.) (under § 4662(b), employee was conclusively presumed to be permanently totally disabled because she had lost the use of both hands).) However, applicant's case does not involve a conclusive statutory presumption of permanent total disability. Moreover, we conclude that apportionment is permissible in cases where permanent total disability has been determined "in accordance with the fact" under section 4662. Section 4663(a) expressly provides that "[a]pportionment of permanent disability shall be based on causation" and section 4664(a) expressly provides that "[t]he employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment." Also, in Brodie v. Workers'Comp. Appeals Bd. (2007) 40 Cal.4th 1313, 1327–1328 [72 Cal.Comp.Cases 565], the Supreme Court observed that sections 4663(a) and 4664(b) create a "new regime of apportionment based on causation" and it held that "the new approach to apportionment is to look at the current disability and parcel out its causative sources-nonindustrial, prior industrial, current industrial-and decide the amount directly caused by the current industrial source." (See also, e.g., Acme Steel v. Workers' Comp. Appeals Bd. (Borman) (2013) 218 Cal.App.4th 1137, 1142–1143 [78 Cal.Comp.Cases 751] (Borman); Benson, supra, 170 Cal.App.4th at pp. 1548, 1559.)."*

among her psychiatric and musculoskeletal injuries (industrial and nonindustrial injuries) that render her incapable of employment on the open labor market. . .Dr. Fujimoto said that applicant could compete in the open labor market based upon her thoracic spine symptoms alone. He said, however, that he could not comment on whether the psychiatric issues by themselves would preclude her from competing on the open labor market."

Dr. Alloy, who reported as the psych th AME, also authored numerous reports and was also deposed. In the end, AME Alloy found apportionment as follows: 75% industrial/ 25% nonindustrial and of the 75% industrial he would apportion 80% thoracic (which appears to relate to the 1999 industrial injury), 10% low back (non-industrial injury later associated with the August 2003 low back discectomy), and 10% neck (non-industrial injury which appears to be the 2004 injury associated with a fusion in August 2008).

". . ..unless an injured employee's overall permanent total disability is predicated on a conclusive statutory presumption under section 4662, the apportionment to causation language of sections 4663(a) and 4664(a) and the case law interpreting these statutes provide that an employee's permanent disability must be apportioned based on its causative sources, even if the overall disability is 100%. (§§ 4663(a), 4664(a); Brodie, supra, 40 Cal.4at pp. 1327–1328; Borman, supra, 218 Cal.App.4th at pp. 1142–1143; Benson, supra, 170 Cal.App.4th at pp. 1548, 1559.) The injured employee has the burden of affirmatively establishing the extent of his or her permanent disability. (§§ 3202.5, 5705.) Thereafter, however, the burden shifts to defendant to prove apportionment. (Pullman Kellogg v. Workers' Comp. Appeals Bd. (Normand) (1980) 26 Cal.3d 450, 456 [45 Cal.Comp.Cases 170]; Kopping v. Workers'Comp. Appeals Bd. (2006) 142 Cal.App.4th 1099, 1115 [71 Cal.Comp.Cases 1229]; Escobedo v. Marshalls (2005) 70 Cal.Comp.Cases 604, 613 (Appeals Board en banc) (Escobedo).)"

Editor's Comment: Dufresne provides a well written and reasoned opinion on the interplay between burden of proof and direct causation in the context of a Labor Code 4663/4664 analysis. The reader should take away from this opinion the fact that regardless of the theory of establishing a permanent disability award, e.g., "Standard AMA rating, ""Guzman," "Ogilivie/LeBouef," or 4662, the disability award will be limited to the whole person impairment and resulting disability which is solely, exclusively, and directly caused by the subject industrial injury.

See also, NBC Universal Media v. WCAB (Moussa) 79 CCC 191 (W/D) which upheld the WCJ's right to apportion based on "range of the evidence" where WCJ adopted, followed and awarded WPI and apportionment for different parts of body from different evaluating physicians. But note the WCJ explained at length why he found different parts of the medical opinions from difference physician to be persuasive and either constitute or not constitute "substantial evidence".

See also, New Axia Holdings v. WCAB (Martinez) 79 CCC 196 (W/D) which held that it was it is the defendant who has the burden of establishing "overlap" under LC 4664, and not the applicant who has the burden of establishing that the prior disability no longer exists citing Kopping 71 CCC 1229.

See also, Gomez v. County of Los Angeles 2014 Cal.Wrk.Comp.P.D. LEXIS 119 (BPD) holding that apportionment under either 4663/4664 is applied to the adjusted disability not WPI.

The VR expert for applicant opined that the applicant was 100% disabled but provided no opinion on whether this was due to the industrial injury, nonindustrial injury, or a combination of the two.

The WCAB in upholding the WCJ found apportionment applying a LC 4663 analysis holding that LC 4662 requires that the total disability must be entirely the direct cause of the subject industrial injury. However, the WCAB rejected the defendant's argument that apportionment under LC 4664 was appropriate to a C&R settlement with a co-defendant citing *Pasquotto v. Hayward Lumber 71 CCC 223,* but noting that *Pasquotto* does not preclude apportionment under LC 4663. Last, the WCAB upheld the WCJ's determination that defendant had failed to meet their burden of proof in establishing apportionment under *Benson 170 Cal.App.4th 1548* on the issue of apportionment as between successive industrial injuries. Therefore, the overall PD was determined to be apportioned 80% industrial and 20% nonindustrial.

". . .We observe, additionally, that while the AME concluded that there were non-industrial factors that caused some of applicant's permanent disability, his reports fail to adequately support his determination with specific explanations of the contributory nature of the non-industrial activities. The AME's opinion is only valid to the extent he identifies and explains the facts that support it. . .the AME failed to identify the facts that demonstrate how the non-industrial factors caused the disability. . .Nowhere in his opinions does [the AME] explain his attribution of disability to 'continuing trauma at home' in that he does not specify how and why applicant's activities of daily living contributed to the extent of his disability."

Editor's comments: This decision could have easily gone for the defendant if the defendant had merely sought clarification from the AME regarding the evidentiary basis for his opinion on apportionment such as the lack of or level of treatment just prior to the MVA; Facts related to the MVA such as speed, whether applicant was safety belted, and vehicle damage; Specific non-industrial ADL's which the applicant was engaging and how they impacted on, contributed to and directly caused the subject disability.

See also, Piper v. WCAB (2012) 77 CCC 661 (Writ Denied) where surveillance video in conjunction with the presence of severe degenerative changes to right knee supported WCJ's finding of less than total disability which was (1) contrary to the testimony of VR expert and (2) consistent with apportionment to successive industrial injuries and non-industrial causation.

See also, Slagle v. WCAB (Department of Corrections) (2012) 77 CCC 467 (Writ Denied) which held that the use of age to support opinion that pathology, (degenerative changes in knee), existed in part due to non-industrial causation, was valid legal apportionment under LC 4663, and not invalid age discrimination, despite relationship between age and degenerative changes where degenerative changes were objectively demonstrative within the applicant's medical records.

Best Buy Company v. WCAB (Nquyen) (2012) 77 CCC 1128 (Writ Denied)

Applicant sustained CT injury for the period ending 8/20/01 and alleged a specific injury as the result of a motor vehicle accident occurring on 8/20/01. Injury was to neck, low back, bilateral legs/feet, gastrointestinal disorder, and hypertension. At the time of both injuries the applicant was employed as a repair technician with Best Buy. The parties selected Dr. Alban as the AME who opined that 20% of the applicant's disability to cervical and lumbar spine was attributable to "continuing trauma at home" or "non-industrial cumulative trauma", and that 50% of the applicants heel condition was apportioned to "non-industrial weight bearing". The AME provided no further explanation or rational for his apportionment to non-industrial causation. Further, the AME found separate dates of injury for the specific and CT as alleged.

The WCJ award refused to follow the opinion of the AME finding only a single CT injury which caused 100% PD without apportionment.

On reconsideration by split panel decision the decision of the WCJ was upheld. First, the Board noted that the AME's report "failed to adequately support his determination with specific explanations of the contributory nature of the non-industrial activities". The Board also held the WCJ properly exercised his role as the trier of fact in making his determination that the specific was merely part of the CT injury rather than a separate injury.

Yellow Transportation v. WCAB 71 CCC 1473 (Writ Denied)

Applicant sustained injury on 7/10/98 and a CT for period ending 6/29/00 to various parts of body. The applicant had prior claims on 3/87 to back and 10/10/87 to neck. All injuries were with the same employer. The parties entered into an
AME who opined that 1/3 was due to degenerative changes; 1/3 to 1987 and the resulting natural progression; 1/3 due to the CT. The WCJ refused to follow the AME finding in that it did not comply with *Escobedo* in that it was not substantial evidence. A key fact seemed to be that although c-spine x-rays taken on 6/2/95 revealed marked degenerative changes, the AME did not himself review the actual films, and an MRI taken six weeks later, on 7/11/95 revealed only minimal bulging at the C3-4 and C5-6 levels without degenerative changes. Further, the MRI of 3/22/00 was interpreted without evidence of herniation, canal stenosis, or forminal encroachment. It was only the MRI taken two years later, on 3/26/02 which showed degenerative disc disease.

Recon denied. Writ Denied.

. . . "the WCJ stated that there was no requirement that she adopt all of the AME's opinion, as long as she states her reasons for rejecting parts of it. With regard to apportionment, [the WCJ noted that Escobedo] requires that a medical opinion be based on reasonable medical probability. [The WCJ] also noted that in his 11/30/04 deposition, [the AME] stated, ***"I think the 'fairest' overview would be one-third to the '87 injury,*** *one-third to the existence of these degenerative changes, and one-third to the June trauma after the condition became symptomatic. . .The WCJ pointed out that although [the AME] explained the nature of Applicant's degenerative changes, he did not explain* ***how or why*** *these changes were responsible for one-third of Applicant's disability. Moreover, the WCJ noted that [the AME] did not explain why the very heavy work Applicant performed in his employment was responsible for only one-third of the Applicant's PD. Under the circumstances, the WCJ did not believe that a 'fair' apportionment was the same as apportionment based on reasonable medical probability and felt that [the AME] had picked the percentage of PD* ***'off the top of his head'."*** *(At page 1475)*

"The apportionment set forth by the AME is speculative and not based upon reasonable medical probability. He specifically gives no reasoning as to why he picked 1/3 of the PD, rather than another fraction, to apportion to each factor, that is, the prior 1987 injury, the degenerative findings/activities of daily living, and the cumulative trauma. Further, [the AME] relies upon 1995 cervical X-ray findings, which are contradicted by the 1995 cervical MRI. . ." (At page 1477).

"It is true that apportionment of permanent disability has been held to be impermissible in cases where an industrial injury gives rise to a conclusive presumption of permanent total disability under section 4662. (E.g., City of Santa Clara v. Workers' Comp. Appeals Bd. (Sanchez) (2011) 76 Cal.Comp.Cases 799 (writ den.) (under § 4662(d), employee was conclusively presumed to be permanently totally disabled because he had sustained an "injury to the brain resulting in incurable mental incapacity or insanity"); Kaiser Foundation Hospitals v. Workers' Comp. Appeals Bd. (Dragomir-Tremoureux) (2006) 71 Cal.Comp.Cases 538 (writ den.) (under § 4662(b), employee was conclusively presumed to be permanently totally disabled because she had lost the use of both hands).) However, applicant's case does not involve a conclusive statutory presumption of permanent total disability. Moreover, we conclude that apportionment is permissible in cases where permanent total disability has been determined "in accordance with the fact" under section 4662. Section 4663(a) expressly provides that "apportionment of permanent disability shall be based on causation" and section 4664(a) expressly provides that "[t]he employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment." Also, in Brodie v. Workers'Comp. Appeals Bd. (2007) 40 Cal.4th 1313, 1327–1328 [72 Cal.Comp.Cases 565], the Supreme Court observed that sections 4663(a) and 4664(b) create a "new regime of apportionment based on causation" and it held that "the new approach to apportionment is to look at the current disability and parcel out its causative sources-nonindustrial, prior industrial, current industrial-and decide the amount directly caused by the current industrial source." (See also, e.g., Acme Steel v. Workers' Comp. Appeals Bd. (Borman) (2013) 218 Cal.App.4th 1137, 1142–1143 [78 Cal.Comp.Cases 751] (Borman); Benson, supra, 170 Cal.App.4th at pp. 1548, 1559.)."

III. Cumulative Trauma Injury and Apportionment of Liability as Between Co-Defendants

A. Discussion with Examples

Apportionment of Liability as between co-defendants again applies the doctrine of "Substantial Evidence" but is a highbred of the elements of "strict legal apportionment" and "Date of CT Injury. Apportionment of liability starts with an analysis to determine the Date of CT injury. Here the focus in on "injurious exposure/activity" and the documented consequence. Here the physician is expected through review of medical records, deposition transcripts, and review of job descriptions, to allocate liability among co-defendant who are either sharing the period of CT or are responsible for successive CT industrial injuries. This analysis is factually dependent and requires the reporting physician to use in equal parts medical knowledge, factual/medical information, and common sense. The primary consideration by the evaluating physician should focus on the physical arduousness of the industrial activity, and/or the intensity of the exposure/stressor in addressing the allocation of liability for the subject injurious exposure/activity period or periods. It is the evaluating physician's analysis that is the most important component to apportionment of liability as between co-defendants.

The first step in the analysis is to determine the date of CT injury: (1) Injurious industrial exposure, (2) Disability and (3) applicant's knowledge or reason to know the existence of a cause and effect relationship.

The second step is: Did the last date of "injurious exposure" occur before or after the "Date of CT Injury". If the "injurious exposure" ended before than the "Date of CT injury", than liability would be on the carrier on the risk during the year ending with the ending of the "injurious exposure/activity/stressor". If the injurious exposure continued beyond "Date of CT Injury" than liability as between co-defendants would be the year period ending upon "Date of CT Injury".

Four Examples/Hypotheticals for Discussion:

(1) Applicant has worked as farm laborer for 20 years and ultimately is taken off work to treatment with disability due to severe degenerative changes to bilateral knees resulting from his activities as a farm laborer. Prior to going off work applicant has no prior disability, including loss time from work, job modification or physical limitations or restrictions. Answer: Liability rolls into 20 year of employment on pro-rata basis.

(2) Applicant has worked 20 years, 10 years as a farm laborer, and 10 years in the farm office answering the phone. All evidence indicates the position answering phone was <u>not</u> injurious. Applicant is taken off work at end of 20 years of work for back surgery with no history of no prior disability, including loss time from work, job modification or physical limitations or restrictions. Answer: Liability rolls into 10 year of employment.

(3) Applicant has worked for 19 years, 10 years as a farm laborer, and is taken off work for 1 year for resulting back surgery, before returning to another 9 years as a farm laborer. At end of 20 year period applicant undergoes low back surgery. Alternatively, assume surgery at 10^{th} year. Answer: Western Growers v. Successive CT?

(4) Applicant has worked for 20 years as a farm laborer. During the last year he worked 6 months as the farm labor supervisor which reduce significantly the physical arduousness of his work. At the conclusion of the 20^{th} year he is taken off work for low back surgery without prior history of disability, including loss time from work, job modification or physical limitations or restrictions. Answer: Liability rolls into last year but allocation may not be pro-rata basis?

(5) Applicant is a sheriff overseeing and eleven officer department. During a two year period preceding a heart attack he is involved in litigation with one of his officer which he testifies is the only stressor related to his job. The litigation is resolved and the stressor ended 6 months before his heart attack. Answer: CT period and therefore liability end with ending of stressor/injurious exposure with liability on pro-rata basis.

B. Relevant Case Law

SCIF v. WCAB (Rodarte) 119 Cal.App. 4th 998, 69 Cal.Comp.Cases 579

See also, accord, City of Anaheim v. WCAB, 75 Cal.Comp.Cases 371; And Trini Rivera v. Fremont Comp et.al 2010 Cal.Wrk.Comp.P.D. LEXIS 56, holding prior Stipulations regarding date of injury may not be used to avoid carrier's right to contribution, rather a determination of either the date of injury, as determined pursuant to Section 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first.

See also, Stanley v. Western Air & Refrigeration 46 Cal.Comp.Cases 197, 1981 Cal.Wrk.Comp. LEXIS 3093; Industrial Indemnity Company v. WCAB (National Steel) 145 Cal.App.3rd 480, 48 CCC 599; Scott Companu v. WCAB (Stanley) 139 Cal.App.3rd 98, 48 CCC 65, asbestosis/mesothelioma case holding the last year of "harmful exposure" which caused the occupational disease, not just exposure is required for the imposition of liability.

Applicant claim a CT injury for the period ending 8/8/98 to right upper extremity resulting in carpal tunnel and tendinitis while employed as an assembler. The applicant's employment was continuous with one company, her employment was through two temporary placement agencies: Apple One 4/95-2/28/98 insured by a carrier in liquidation admistered by CIGA; Temptrak 3/1/98-8/7/98 insured by SCIF. On 10/3/97 Rodarte received medical treatment which included anti-inflammatory medicals, a wrist brace, and physical therapy, with the PTP permitting applicant to return to modified work. Rodarte filed a claim on 10/97. Rodarte continued to work without her managers knowledge of the injury. Althogh Rodarte's manager initially provided accomodations, Rodarte's was terminated upon finding out about the injury based upon the fact the applicant could not do her job duties. At hearing Rodarte testified she would have continued but for being terminated.

The AME found a continuous CT through 8/98 when Rodarte quit working. The WCJ found a single CT for the period ending with the applicants termination8/7/98, last year of work, which found SCIF liable for the entire claim.

On reconsideration the WCAB reversed holding (1) that the date of injury under section 5500.5 requires compensable temporary disability *or* permanent disability; (2) Modified work is insufficient to establish TD which requires actual wage loss (3) but modified work may indicate a *permanent* impairment of earning capacity for the establishment of PD under 5412 necessary to establish a CT injury; and (4) under LC 5500.5 provides that liability for occupational disease or cumulative injury claims shall be limited to those employers who employed the employee during the period of one year "[I]mmediately preceding either the date of injury, as determined pursuant to Section 5412, or the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury, whichever occurs first."; and (5) medical treatment alone is not disability, but it may be evidence of compensable permanent disability, as may a need for splints and modified work. Remanded.

Roger Bass v State of California, Dept. of Corrections & Rehabilitation 82 Cal Comp Cases 1034, 2017 Cal.Wrk.Comp. P.D. LEXIS 213 (BPD)

Applicant, a correctional officer for over 30 years, sustained a CT injury for the period ending 7/15/14, to heart, neck, low back, right knee, and left foot. Although Applicant continued to work in his normal and customary job without restriction, he received treatment provided by the employer for a number of years to chronic neck, low back, right knee, and left foot pain. Although the parties stipulated that the orthopedic injuries and injury to heart were the result of a single cumulative injury, the defendant's contended that since the disease process for each type of injury was from different causes, there should be two separate awards, one for orthopedic injury, and one for injury to heart. After trial the WCJ held a single CT, and an awarded PD without application of the CVE, merely adding the disability for the orthopedic injury to the disability for the injury to heart.

Editor's Comments: The decision of Bass v. State of California, Dept. of Corrections is important for two reasons. First, this is the first reported decision that expressly prohibits the WCJ from deciding whether or not to apply the CVE. In the absence of medical evidence on this issue it appears the WCJ must either apply the CVE or perhaps request further development of the medical record. Second, although separate parts or conditions may be injured, where the injurious period in the same, a single CT injury will be found. Here however, if the defendant had established that the injurious exposure for orthopedic injury was different from that of the injury to heart, the result might have been different.

Apportionment of Liability as between co-defendants again applies the doctrine of "Substantial Evidence" but is a hybred of the elements of "strict legal apportionment" and "Date of CT Injury. Apportionment of liability starts with an analysis to determine the Date of CT injury. Here the focus in on "injurious exposure/activity" and the documented consequence. Here the physician is expected through review of medical records, deposition transcripts, and review of job descriptions, to allocate liability among co-defendant who are either sharing the period of CT or are responsible for successive CT industrial injuries. This analysis is factually dependent and requires the reporting physician to use in equal parts medical knowledge, factual/medical information, and common sense. The primary consideration by the evaluating physician should focus on the physical arduousness of the industrial activity, and/or the intensity of the exposure/stressor in addressing the allocation of liability for the subject injurious exposure/activity period or periods. It is the evaluating physician's analysis that is the most important component to apportionment of liability as between co-defendants.

The first step in the analysis is to determine the date of CT injury: (1) Injurious industrial exposure, (2) Disability and (3) applicant's knowledge or reason to know the existence of a cause and effect relationship.

The second step is: Did the last date of "injurious exposure" occur before or after the "Date of CT Injury". If the "injurious exposure" ended before than the "Date of CTinjury", than liability would be on the carrier on the risk during the year ending with the ending of the "injurious exposure/activity/stressor". If the injurious exposure continued beyond "Date of CT Injury" than liability as between co-defendants would be the year period ending upon "Date of CT Injury".

In upholding the WCJ, the WCAB held that even though there were two different dates of injury under Labor Code § 5412 for applicant's heart and orthopedic injuries, there was a single period of injurious exposure for purposes of determining liability under Labor Code § 5500.5. Further, that while the date of injury under Labor Code § 5412 has relevance to statute of limitations and perhaps allocation of liability for cumulative injury under Labor Code § 5500.5, it does not determine whether employee sustained one or two cumulative injuries. Here the WCAB held a single period of injurious industrial exposure was responsible for both injury to spine, right knee/left foot, as well as to heart. As to whether the disability should be added or the CVE should be applied, the WCAB held that this was a medical question and because the medical record was silent on the issue the matter was remanded for development of the medical record.

SCIF v. WCAB (Dorsett) (6th District Court of Appeal, 2011) 76 CCC 1138

Applicant sustained a specific injury to cervical spine on 3/21/00 while working for South Valley Glass and a CT injury to cervical spine for the period ending 6/8/04 while working for A-Tek. Both were insured by SCIF. The AME wrote that in the absence of the specific injury in 2000, the subsequent activities with the second employer would not have been injurious and therefore the subsequent CT would not have occurred. At deposition the AME testified "if the initial [injury] doesn't happen. . .the second [injury] can't happen because there's no indication medically that he would have had any disability in 2004 absent the first injury of 2000." Even so, the AME apportioned the disability equally as between the two injuries. Based upon the opinion of the AME, the WCJ made a 100% award, refusing to apportion, finding only a single injury in that the second injury was a compensable consequence of the original injury. Defendant sought reconsideration and after denial, a Writ of Review.

> *". . .Employers must compensate injured workers only for that portion of their permanent disability attributable to a current industrial injury, not for that portion attributable to previous injuries or to nonindustrial factors. . .Apportionment is now based on causation. . .the new approach to apportionment is to look at the current disability and parcel out its causative sources – nonindustrial, prior industrial, current industrial – and decide the amount directly caused by the current industrial source. . . Therefore, evaluating physicians, WCJ and WCAB must make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of the [industrial injury]. . .and caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. . .*
>
> *There may be limited circumstances. . . when the evaluating physician cannot parcel out, with reasonable medical probability, the approximate percentage to which each distinct industrial injury causally contributed to the employee's overall permanent disability. In such limited circumstances, when the employer has failed to meet its burden of proof, a combined award may still be justified. . .the burden of proof falls on the employer for it is the employer who benefits from apportionment.*
>
> *SCIF v. WCAB (Dorsett) 76 CCC at pg. 1144.*

The Court of Appeal discussed at length whether a subsequent injurious industrial activity can be a compensable consequence of a prior injury for the purpose of avoiding apportionment under LC 4663. In the end, the Court reversed holding that separate injuries had occurred and since the AME had been able to apportion as between these injuries the WCJ was compelled to find apportionment. The Court also seemed to stress that it would be a rare situation where apportionment would not exist were successive injuries are involved.

> *See also, Pruitt v. California Department of Corrections, SCIF 2011 Cal. Wrk. Comp, P.D. Lexis 553(Panel Decision) (involving inmate firefighter jumping 6 feet down to escape fire) in which the decision of WJC finding no apportionment was reversed where based upon the opinion of the PTP who noted "in this case, there is nothing in the medical records that shows that the patient had any problem with her bilateral knees prior to her industrial injury. . .[or that] absent her industrial injury [the applicant would have any disability] . . . Therefore, apportionment to pre-existing or other factors is not warranted." The WCAB in reversing found that the medical opinion relied upon was premised on an incorrect legal theory and did not, therefore, constitute substantial medical evidence.*
>
> *But see contra, Bridgestone Firestone v. WCAB Fussell (2011) 76 CCC 1326 (Writ Denied) in which the finding of no apportionment to pre-existing diabetes which was under control was upheld. See also, contra, Cal. Indemnity Insurance Co. v. WCAB (Whiteley) 76 CCC 1332 (Writ Denied) in which no apportionment to CT, where substantial medical evidence attributed all of applicant's symptoms and impairment to specific injury only.*
>
> *Editor's Comments: It should be noted that the Dorsett decision is also valuable on the issue of whether the defendant on a subsequent injury may avoid liability arguing that the second injury is merely a compensable consequence of the original injury (prior) industrial injury. Traditionally, the principle of "compensable consequence" has been limited to non-industrial conditions or activities which result in an increase in the need for medical treatment, to extend periods of TD or an increased in PD. Where the subsequent injurious activity is industrial, a second industrial injury has occurred. The rationale for this is that (1) the an employer takes the employee as he find him, and (2) will be held responsible for that portion of PD which is directly and causally related to an injurious industrial activity or exposure, despite the fact that a prior injury may make the applicant/employee more susceptible to injury.*

Document:70 Cal. Comp. Cases 604

70 Cal. Comp. Cases 604

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70 Cal. Comp. Cases 604 * 2005 Cal. Wrk. Comp. LEXIS 71 **

Marlene Escobedo, Applicant v. Marshalls, CNA Insurance Co., Defendants

Subsequent History:

[**1]

Writ of Review Denied September 9, 2005 sub nom. *Escobedo v. W.C.A.B.* (2005) 70 Cal. Comp. Cas 1506; Review Denied November 16, 2005

Disposition: The Findings and Award issued June 29, 2004, is *affirmed.*

Core Terms

apportionment, permanent disability, disability, industrial injury, non-industrial, knee, percentage of permanent disability, preexisting, pathology, permanent, substantial evidence, *disease, left knee, workers' compensation, medical evidence, right knee, degenerative arthritis,* issue of causation, legislative intent, en banc, cumulative, reconsider, baker, burden of establishing, bilateral, retroactive, arthritis, causally

Headnotes

CALIFORNIA COMPENSATION CASES HEADNOTES

Permanent Disability—Apportionment—SB 899—Causation—WCAB en banc, affirming WCJ's apportionment decree issued pursuant to SB 899, held that Labor Code § 4663(a)'s requirement that apportionment be based on "causation" refers to causation of permanent disability, not to causation of injury, and that analysis of causal factors of permanent disability for purposes of apportionment may be different from analysis of causal factors of injury, in that percentage to which applicant's injury is causally related to employment is not necessarily same as percentage to which applicant's permanent disability is causally related to injury. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[1]-[3], 8.06[1], [4], [5][c][iii], 8.07[1].]

[*605] Permanent Disability—Apportionment—SB 899—Apportionment Determinations—WCAB en banc held that Labor Code § 4663(c) not only prescribes apportionment determinations that reporting physician must make, but also prescribes [2] standards WCAB must use in deciding apportionment, so that both physician and WCAB must make determinations of percentage of permanent disability directly caused by industrial injury and percentage caused by other factors.** [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[1]-[3], 8.06[1], [4], [5][c][iii], 8.07[1].]

Permanent Disability—Apportionment—SB 899—Burdens of Proof—WCAB en banc held that, under Labor Code § 4663(c), applicant has burden of establishing percentage of permanent disability directly caused by industrial injury, and defendant has burden of establishing percentage of disability caused by other factors. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[1]-[3], 8.06[1], [4], [5][c][iii], 8.07[1].]

Permanent Disability—Apportionment—SB 899—Factors to Be Considered in Apportionment—WCAB en banc held that apportionment of permanent disability caused by, in words of Labor Code § 4663(c), "other factors both before and subsequent to the industrial injury, including prior industrial injuries" may include not only disability that could have been apportioned prior to SB 899, but also may include disability that formerly could [3] not have been apportioned (e.g., pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions), provided there is substantial medical evidence establishing that these other factors have caused permanent disability, so that in present case apportionment could be based on non-industrial pathology, since substantial medical evidence established that non-industrial pathology had caused permanent disability.** [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[1]-[3], 8.06[1], [4], [5][c][iii], 8.07[1].]

Permanent Disability—Apportionment—SB 899—Medical Reports as Substantial Evidence—WCAB en banc held that, even when medical report addresses issue of causation of permanent disability and makes apportionment determination by finding approximate

relative percentages of industrial and non-industrial causation under Labor Code § 4663(a), **report may not be relied on unless it also constitutes substantial evidence, which means that medical opinion must be framed in terms of reasonable medical probability, must not be speculative, must be based on pertinent facts and on adequate examination and history, and must set forth reasoning in support** [**4] **of its conclusions, all of which requirements were satisfied by medical report relied on by WCJ in present case that involved preexisting degenerative arthritis in both of applicant's knees.** [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[1]-[3], 8.06[1], [4], [5][c][iii], 8.07[1]; Attorneys' Textbook of Medicine, Chs. 7A, 19; Common Diagnostic Procedures, Chs. 2, 24, 30.].

Opinion By: Chairman Merle C. Rabine

Opinion

[*604] OPINION AND DECISION AFTER RECONSIDERATION (EN BANC)

The Appeals Board granted reconsideration of the June 29, 2004 Findings and Award issued by the workers' compensation administrative law judge ("WCJ"), to further study the record and the applicable law. This is our Decision After Reconsideration.

In the June 29, 2004 decision, the WCJ found that Marlene Escobedo ("applicant") sustained an October 28, 2002 industrial injury to her left knee, and to her right knee as a compensable consequence, while employed as a sales associate by Marshalls, the insured of CNA Insurance Company ("defendant"). In relevant part, the WCJ also found that applicant's bilateral knee injury entitled her to a 27% permanent disability award, after determining that 50% of her permanent [**5] disability was caused by the effects of preexisting degenerative arthritis in both knees. The WCJ applied the provisions of Labor Code section 4663, [1] as enacted by Senate Bill 899 ("SB 899") and effective on April 19, 2004 (Stats. 2004, ch. 34, § 34), in making this 50% apportionment determination.

In her petition for reconsideration, applicant contends in substance: (1) new section 4663 cannot be retroactively applied to cases where the date of injury was prior to the effective date of SB 899; (2) new section 4663 does not authorize the apportionment of disability to pathology in the absence of *express legislative intent; and* (3) the *medical report relied upon by the WCJ to justify apportionment* to applicant's preexisting arthritis does not constitute substantial medical evidence because it fails to explain in adequate detail how that condition caused permanent disability. [2] Defendant filed an answer to applicant's petition, and the WCJ prepared a Report and Recommendation on Petition for Reconsideration ("Report") recommending that a petition be denied.

Because of the important legal issues presented as to the meaning and application of section 4663 with regard to the issue of apportionment of permanent disability based on causation, and in order to secure uniformity of decision in the future, the Chairman of the Appeals Board, upon a majority vote of its members, assigned **[*607]** this case to the Appeals Board as a whole for an en banc decision. (Lab. Code, § 115.) [3] Based on our review of the relevant statutory and case law, we hold that:

> "1) Section 4663(a)'s statement that the apportionment of permanent disability shall be based on "causation" refers to the causation of the permanent disability, not causation of the injury, and the analysis [**7] of the causal factors of permanent disability for purposes of apportionment may be different from the analysis of the causal factors of the injury itself.
>
> 2) Section 4663(c) not only prescribes what determinations a reporting physician must make with respect to apportionment, it also prescribes what standards the WCAB must use in deciding apportionment; that is, both a reporting physician and the WCAB must

make determinations of what percentage of the permanent disability was directly caused by the industrial injury and what percentage was caused by other factors.

3) Under section 4663, the applicant has the burden of establishing the percentage of permanent disability directly caused by the industrial injury, and the defendant has the burden of establishing the percentage of disability caused by other factors.

4) Apportionment of permanent disability caused by "other factors both before and subsequent to the industrial injury, including prior industrial injuries," may include not only disability that could have been apportioned prior to SB 899, but it also may include disability that formerly could not have been apportioned (e.g., pathology, asymptomatic prior conditions, and retroactive [**8] prophylactic work preclusions), provided there is substantial medical evidence establishing that these other factors have caused permanent disability.

5) Even where a medical report "addresses" the issue of causation of the permanent disability and makes an "apportionment determination" by finding the approximate relative percentages of industrial and non-industrial causation under section 4663(a), the report may not be relied upon unless it also constitutes substantial evidence."

BACKGROUND

Applicant sustained injury to her left knee on October 28, 2002, when she fell at her job as a sales associate with Marshalls, a retail clothing store. As a compensable consequence of that injury, she also developed right knee problems.

[*608] Applicant testified that, [**9] prior to her fall, she had never had any knee problems or limitations, and she never consulted a doctor about her knees. Although her treating physician, Dr. Cronin, had diagnosed her as having arthritis about ten years earlier, he did not impose any work restrictions as a consequence of her arthritis.

Applicant was treated for her industrial injury by Daniel Woods, M.D., who performed arthroscopic surgery on February 12, 2003, to repair the medial meniscus in the left knee. On June 5, 2003, Dr. Woods prepared a report declaring applicant to be permanent and stationary with bilateral knee disability resulting in a limitation to semi-sedentary work. He noted that applicant's job duties at Marshalls had required her to be on her feet, standing or walking, six to eight hours per day, and to kneel or squat up to three hours per day. He had attempted to have her return to work four hours per day, but she was unable to tolerate it because of right knee pain. With regard to the issue of apportionment, Dr. Woods noted that applicant had no history of any previous problems with her left knee, and thus he concluded that all of her disability was attributable to her industrial injury.

Defendant's [**10] qualified medical examiner ("QME"), Daniel Ovadia, M.D., evaluated applicant on March 15, 2004 and prepared a report on that date. He noted that a pre-surgical MRI of applicant's left knee revealed degenerative changes, in addition to the medial meniscus tear, and that post-surgical x-rays showed osteoarthritis in both knees. Dr. Ovadia concluded, based on applicant's bilateral knee condition: that she was limited to four hours of weight bearing in an eight-hour day; that she should avoid very heavy work; that she should avoid more than occasional kneeling, squatting, or walking on uneven ground; that she should avoid stair, incline and ladder climbing; and that she is totally precluded from running or jumping. With regard to apportionment, Dr. Ovadia stated:

""Ms. Escobedo's left knee residuals are directly related to the October 28, 2002 injury. The Applicant developed right knee problems as a derivative of the left knee and not as a result of any subsequent cumulative trauma. In my opinion, there is a medically reasonable basis for apportionment given the trivial nature of the injury that occurred on October 28, 2002 and the almost immediate onset of right knee symptoms that occurred [**11] shortly after the left knee injury. The Applicant has obvious, significant degenerative arthritis in both knees and essentially worked in a fairly congenial environment. Although denying any prior problems with her knees, it is medically probable that she would have had fifty percent of her current level of knee disability at the time of today's evaluation even in the absence of her employment at Marshalls. Dr. Woods did not take this into account when he discussed the issue of apportionment.

> Furthermore, when he saw the Applicant, he thought she had a lateral meniscus tear which was clearly not the case based on his operative findings (leading edge tears are of no clinical significance and would not have accounted for the Applicant's pathology and **[*609]** disability which relate to the medial and patellofemoral compartments).""

Dr. Woods responded to Dr. Ovadia's conclusions on May 22, 2004, after he re-examined applicant. *Dr. Woods found no basis for apportionment, stating:*

> ""The patient prior to her industrial injury of October 28, 2003, was not suffering from any disability relative to her knees. She indicates that she was able to walk in unlimited fashion and had been able to work. She [**12] clearly has disability at this time which I have, in the absence of previously documented disability, attributed to her industrial injury.""

The WCJ determined that, overall, applicant's bilateral knee disability rated 53%, based on the factors of disability outlined in Dr. Ovadia's March 14, 2004 report. The WCJ, however, also apportioned 50% of applicant's permanent disability to non-industrial causation under section 4663, relying on Dr. Ovadia's opinion that one-half of the disability was caused by her preexisting degenerative arthritis.

DISCUSSION

I.

We briefly address applicant's contention that new section 4663 does not apply to injuries sustained before the April 19, 2004 effective date of SB 899. This issue has been resolved by *Kleemann v. Workers' Comp. Appeals Bd.* (2005) 127 Cal.App.4th 274 [25 Cal. Rptr. 3d 448] [70 Cal.Comp.Cases 133], which held that the procedural and substantive aspects of new section 4663 apply to all cases that were pending as of the date of SB 899's enactment on April 19, 2004, as here. [4]

II.

Section 4663 as amended by SB 899 provides:

> ""(a) Apportionment of permanent disability shall be based on causation.
>
> "(b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.
>
> "(c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the **[*610]** course of employment and what approximate percentage of the permanent disability was caused by other factors [**14] both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.
>
> "(d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.""

Also, newly enacted section 4664(a) states:

> ""The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.""

In construing a statute, the Appeals Board's fundamental purpose is to determine and effectuate the Legislature's intent. (*DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 387 [853 P.2d 978, 20 Cal. Rptr. 2d 523] [58 Cal.Comp.Cases 286]; [**15] *Nickelsburg v. Workers' Comp. Appeals Bd.* (1991) 54 Cal.3d 288, 294 [814 P.2d 1328, 285 Cal. Rptr. 86] [56 Cal.Comp.Cases 476]; *Moyer v. Workmen's Comp. Appeals Bd.* (1973) 10 Cal.3d 222, 230 [514 P.2d 1224, 110 Cal. Rptr. 144] [38 Cal.Comp.Cases 652].) Thus, the WCAB's first task is to look to the language of the statute itself. (*Ibid.*) The best indicator of legislative intent is the clear, unambiguous, and plain meaning of the statutory language. (*DuBois v. Workers' Comp. Appeals Bd., supra,* 5 Cal.4th at pp. 387–388; *Gaytan v. Workers' Comp. Appeals Bd.* (2003) 109 Cal.App.4th 200, 214 [134 Cal. Rptr. 2d 516] [68 Cal.Comp.Cases 693]; *Boehm & Associates v. Workers' Comp. Appeals Bd. (Lopez)* (1999) 76 Cal.App.4th 513, 516 [90 Cal. Rptr. 2d 486] [64 Cal.Comp.Cases 1350].) When the statutory language is clear and unambiguous, there is no room for interpretation and the WCAB must simply enforce the statute according to its plain terms. (*DuBois v. Workers' Comp. Appeals Bd., supra,* 5 Cal.4th at p. 387; *Atlantic Richfield Co. v. Workers' Comp. Appeals Bd. (Arvizu)* (1982) 31 Cal.3d 715, 726 [644 P.2d 1257, 182 Cal. Rptr. 778] [47 Cal.Comp.Cases 500]; *Cal. Ins. Guar. Ass'n v. Workers' Compensation Appeals Bd. (Karaiskos)* (2004) 117 Cal.App.4th 350, 355 [12 Cal. Rptr. 3d 12] [69 Cal.Comp.Cases 183].) [**16]

[*611]

A.

Section 4663(a)'s Statement That The Apportionment Of Permanent Disability Shall Be Based On "Causation" Refers To The Causation Of The Permanent Disability, Not Causation Of The Injury, And The Analysis Of The Causal Factors Of Permanent Disability For Purposes Of Apportionment May Be Different From The Analysis Of The Causal Factors Of The Injury.

Section 4663(a) states that "[a]pportionment of permanent disability shall be based on causation." The plain reading of "causation" in this context is causation *of the permanent disability.* This reading is consistent with other provisions of section 4663 and 4664. That is: (1) section 4663(b) provides that a physician's report on permanent disability shall address "the issue of *causation of the permanent disability;*" (2) section 4663(c) provides that a physician's report shall find "what approximate percentage of the *permanent disability was caused* by the direct result of injury . . . and what approximate percentage of the *permanent disability was caused* by other factors;" and (3) section 4664(a) provides that an employer "shall only be liable for the percentage of *permanent disability* directly *caused* by the injury. . . . " (Emphases [**17] added.) [5] The issue of the causation of permanent disability, for purposes of apportionment, is distinct from the issue of the causation of an injury. (See *Reyes v. Hart Plastering* (2005) 70 Cal.Comp.Cases 223 (Significant Panel Decision).) Thus, the percentage to which an applicant's *injury* is causally related to his or her employment is not necessarily the same as the percentage to which an applicant's *permanent disability* is causally related to his or her injury. The analyses of these issues are different and the medical evidence for any percentage conclusions might be different.

B.

Section 4663(c) Not Only Prescribes What Determinations A Reporting Physician Must Make With Respect To Apportionment, It Also Prescribes What Standards The WCAB Must Use In Deciding Apportionment; That Is, Both A Reporting Physician And The WCAB Must Make Determinations Of What Percentage Of The Permanent Disability [18] Was Directly Caused By The Industrial Injury And What Percentage Was Caused By Other Factors.**

Section 4663(c) provides, in part:

> ""In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding **[*612]** what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the

industrial injury, including prior industrial injuries.""

Section 4663(c) refers only to *a reporting physician's* duty to make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of the injury and what approximate percentage was caused by other factors. We conclude the same standards apply to the *adjudication* of permanent disability and apportionment, i.e., the WCAB must find what percentage of the permanent disability was directly caused by the injury and what percentage was caused by other factors. [**19] This conclusion is consistent both with the statement in section 4663(a) that "[a]pportionment of permanent disability shall be based on causation" and with the statement in section 4664(a) that "[t]he employer shall only be liable for the percentage of permanent disability directly caused by the injury."

C.

The Applicant Has The Burden Of Establishing The Percentage Of Permanent Disability Directly Caused By The Industrial Injury, While The Defendant Has The Burden Of Establishing The Percentage Of Disability Caused By Other Factors.

Under SB 899, the applicant continues to have the initial burden of establishing an industrial injury by a preponderance of the evidence. (Lab. Code §§3202.5, 5705; *McAllister v. Workers' Comp. Appeals Bd.* (1968) 69 Cal.2d 408, 416 [445 P.2d 313, 71 Cal. Rptr. 697] [33 Cal.Comp.Cases 660].) In addition, he or she still has the burden of proving, by a preponderance of the evidence, both the overall level of permanent disability and that at least some of this permanent disability was industrially-caused. (Lab. Code, §§3202.5, 5705; see *Peter Kiewit Sons v. Industrial Acc. Com. (McLaughlin)* (1965) 234 Cal.App.2d 831, 838 [44 Cal. Rptr. 813] [30 Cal.Comp.Cases 188]; [**20] *Sweeney v. Industrial Acc. Com.* (1951) 107 Cal.App.2d 155, 158–159 [236 P.2d 651] [16 Cal.Comp.Cases 264].)

In accordance with section 4663(c), however, we conclude the applicant now also has the burden of establishing the approximate percentage of permanent disability directly caused by the industrial injury. The assignment of this burden to the applicant is consistent with Labor Code section 5705, which provides in relevant part: "The burden of proof rests upon the party . . . holding the affirmative of the issue." It is also consistent with Evidence Code section 500 , which provides that "a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting." Because it is the applicant who claims permanent disability benefits, and because the applicant can be compensated only for industrially-caused permanent disability, it is incumbent upon him or her to present evidence establishing the percentage of permanent disability directly caused by the industrial injury.

[*613] We also conclude, in accordance with section 4663(c), that the defendant has the burden of establishing the approximate percentage [**21] of permanent disability caused by factors other than the industrial injury. Again, the assignment of this burden to the defendant is consistent with Labor Code section 5705 and Evidence Code section 500. It is also consistent with the longstanding principle that, because it is the defendant that benefits from a finding of apportionment, it bears the burden of demonstrating that apportionment is appropriate. (*Pullman Kellogg v. Workers' Comp. Appeals Bd. (Normand)* (1980) 26 Cal.3d 450, 456 [605 P.2d 422, 161 Cal. Rptr. 783] [45 Cal.Comp.Cases 170].) 6 Under section 4663, it is still the defendant that benefits from a finding of apportionment, and we discern no legislative intent to do away with this long-established principle in the context of apportionment to non-industrial causation. (See *People v. Superior Court (Zamudio)* (2000) 23 Cal.4th 183, 199 [999 P.2d 686, 96 Cal. Rptr. 2d 463] (when the Legislature enacts a statute, it is presumed the Legislature did not intend to overthrow long-established principles of law unless such an intention is clearly expressed or necessarily implied); accord: *Torres v. Automobile Club of So. Cal.* (1997) 15 Cal.4th 771, 779 [937 P.2d 290, 63 Cal. Rptr. 2d 859]; [**22] *Fuentes v. Workers' Comp. Appeals Bd.* (1976) 16 Cal.3d 1, 7 [547 P.2d 449, 128 Cal. Rptr. 673] [41 Cal.Comp.Cases 42]; *Theodor v. Superior Court* (1972) 8 Cal.3d 77, 92 [501 P.2d 234, 104 Cal. Rptr. 226].)

These burdens apply whether there is one reporting physician (e.g., an agreed medical evaluator or a panel QME) or more than one reporting physician. Where a dispute arises on the issue of apportionment to industrial or non-industrial causation, a party's options include but are not limited to: (1) doing nothing, based on a belief that the assessment of the relative industrial and non-

industrial causation percentages by the physician(s) upon whom it intends to rely is the most persuasive [**23] substantial medical evidence; (2) obtaining a supplemental report to clarify or bolster the percentage causation determination of the physician upon who it intends to rely or, if there is more than one physician, to rebut the opposing physician's percentage causation determinations; or (3) cross-examining the physician(s) by deposition for the same reasons.

If the reporting physicians disagree regarding the overall level of permanent disability and/or regarding the approximate percentages of industrially and non-industrially caused permanent disability, or if a party disagrees with the opinion of a reporting physician, then the WCJ (or the Appeals Board) must weigh the evidence appropriately and determine these issues based on the most persuasive substantial medical evidence.

[*614] The criteria that a medical opinion must meet in order to constitute substantial evidence on the issue of the overall level of permanent disability and, in particular, on the issue of the relative percentages of industrial and non-industrial causation will be discussed below, in Section II-E.

D.

Apportionment Of Permanent Disability Caused By "Other Factors Both Before And Subsequent To The Industrial Injury, [24] Including Prior Industrial Injuries," May Include Not Only Disability That Could Have Been Apportioned Prior To SB 899, But It Also May Include Disability That Formerly Could Not Have Been Apportioned (E.g., Pathology, Asymptomatic Prior Conditions, And Retroactive Prophylactic Work Preclusions), Provided There Is Substantial Medical Evidence Establishing That These Other Factors Have Caused Permanent Disability.**

Prior to SB 899, the apportionment of permanent disability was based largely on the grounds specified in former sections 4663, 4750, and 4750.5. (*Fresno Unified School Dist. v. Workers' Compensation Appeals Bd. (Humphrey), supra,* 84 Cal.App.4th at p. 1305; *Franklin v. Workers' Comp. Appeals Bd.* (1978) 79 Cal.App.3d 224, 236 [145 Cal. Rptr. 22] [43 Cal.Comp.Cases 310].)
7 Former section 4663 provided:

> ""In case of aggravation of any disease existing prior to a compensable injury, compensation shall be allowed only for the proportion of the disability due to the aggravation of such prior disease which is reasonably attributed to the injury.""

In order to apportion under former section 4663, there must have been medical evidence establishing that some definable portion of the applicant's permanent disability would have occurred as the result of the natural progression of a non-industrial condition [**26] or disease, even absent the industrial injury. (*Pullman Kellogg v. Workers' Comp. Appeals Bd. (Normand), supra,* 26 Cal.3d at p. 454; *Zemke v. Workmen's Comp. Appeals Bd.* (1968) 68 Cal.2d 794, 796 [441 P.2d 928, 69 Cal. **[*615]** Rptr. 88] [33 Cal.Comp.Cases 358].) While it was not necessary that the preexisting condition or disease have been symptomatic and disabling at the time of the industrial injury (*Duthie v. Workers' Comp. Appeals Bd.* (1978) 86 Cal.App.3d 721, 728 [150 Cal. Rptr. 530] [43 Cal.Comp.Cases 1214]; *Callahan v. Workers' Comp. Appeals Bd.* (1978) 85 Cal.App.3d 621, 629 [149 Cal. Rptr. 647] [43 Cal.Comp.Cases 1097]; *Franklin v. Workers' Comp. Appeals Bd., supra,* 79 Cal.App.3d at p. 245), it was necessary that the non-industrial disability would have developed by the time that the injured worker's industrial disability became permanent and stationary; i.e., it was insufficient that the non-industrial disability would have occurred at some indefinite future date. (*Gay v. Workers' Comp. Appeals Bd.* (1979) 96 Cal.App.3d 555, 562 [158 Cal. Rptr. 137] [44 Cal.Comp.Cases 817]; *Duthie v. Workers' Comp. Appeals Bd., supra,* 86 Cal.App.3d at p. 728; *Frannklin [sic] v. Workers' Comp. Appeals Bd., supra,* 79 Cal.App.3d at p. 243.)

Former [**27] section 4750 provided:

> ""An employee who is suffering from a previous permanent disability or physical impairment and sustains permanent injury thereafter shall not receive from the employer compensation for the later injury in excess of the compensation allowed for such injury when considered by itself and not in conjunction with or in relation to the previous disability or impairment. [P] The employer shall not be liable for compensation to such an employee for the combined disability, but only for that portion due to the later injury as though no prior disability or impairment had existed.""

In order to apportion under former section 4750, there must have been evidence of a preexisting condition that was in fact labor disabling prior to the occurrence of the industrial injury in question; that is, there must have been disability which would have been ratable had it been industrially caused. (*Ditler v. Workers' Comp. Appeals Bd.* (1982) 131 Cal.App.3d 803, 812 [182 Cal. Rptr. 839] [47 Cal.Comp.Cases 492]; *Robinson v. Workers' Comp. Appeals Bd., supra,* 114 Cal.App.3d at p. 602; *Franklin v. Workers' Comp. Appeals Bd., supra,* 79 Cal.App.3d at p. 237.) Preexisting disability, however, [**28] could not be established by a "retroactive prophylactic work restriction," that is, medical opinion that retroactively imposed a work limitation upon the injured worker, which opinion was postulated after the industrial injury and was made in the absence of evidence that the worker actually had been restricted in his or her work activities prior to the industrial injury. (*Ditler v. Workers' Comp. Appeals Bd., supra,* 131 Cal.App.3d at p. 814; *Robinson v. Workers' Comp. Appeals Bd., supra,* 114 Cal.App.3d at p. 602; *Franklin v. Workers' Comp. Appeals Bd., supra,* 79 Cal.App.3d at p. 238.)

Under both former sections 4663 and 4750, it was the permanent disability resulting from, not the cause of, a disease or condition which was the proper subject of apportionment; apportionment to "pathology" was not permissible. (*Pullman Kellogg v. Workers' Comp. Appeals Bd. (Normand), supra,* 26 Cal.3d at pp. 454–455, 456 [at fn. 4]; *Fresno Unified School Dist. v. Workers' Compensation Appeals* **[*616]** Bd. (Humphrey), supra, 84 Cal.App.4th at p. 1304; *Ashley v. Workers' Comp. Appeals Bd., supra,* 37 Cal.App.4th at p. 327; *King v. Workers' Comp. Appeals Bd.* (1991) 231 Cal.App.3d 1640, 1647 [283 Cal. Rptr. 98] [56 Cal.Comp.Cases 408]; [**29] *Duthie v. Workers' Comp. Appeals Bd., supra,* 86 Cal.App.3d at p. 728; *Franklin v. Workers' Comp. Appeals Bd., supra,* 79 Cal.App.3d at p. 243.)

Former section 4750.5 provided:

> ""An employee who has sustained a compensable injury and who subsequently sustains an unrelated noncompensable injury, shall not receive permanent disability indemnity for any permanent disability caused solely by the subsequent noncompensable injury.""

Under former section 4750.5, an applicant could not receive permanent disability benefits for a post-injury disabling event that, had it been work-related, would have been compensable. (*Fresno Unified School Dist. v. Workers' Compensation Appeals Bd. (Humphrey), supra,* 84 Cal.App.4th at p. 1305; *Ashley v. Workers' Comp. Appeals Bd.* (1995) 37 Cal.App.4th 320, 327–329 [43 Cal. Rptr. 2d 589] [60 Cal.Comp.Cases 683].)

SB 899, however, repealed former sections 4663, 4750, and 4750.5 (Stats. 2004, ch. 34, §§33, 37, 38) and it enacted new sections 4663 and 4664. (Stats. 2004, ch. 34, §§34, 35.) There is no doubt that, in taking this action, the Legislature intended to significantly change the law relating to apportionment of permanent disability. (See *People v. Mendoza* (2000) 23 Cal.4th 896, 916 [4 P.3d 265, 98 Cal. Rptr. 2d 431] [**30] (the repeal of a prior statute, together with enactment of a new law on the same subject with important changes, strongly suggests the Legislature intended to change the law); *In re Lance W.* (1985) 37 Cal.3d 873, 887 [694 P.2d 744, 210 Cal. Rptr. 631] (general rule is that a new enactment reflects a legislative purpose to change existing law); *Mosk v. Superior Court* (1979) 25 Cal.3d 474, 493 [601 P.2d 1030, 159 Cal. Rptr. 494] (a substantial change in the language of a statute by an amendment indicates an intention to change its meaning).)

We conclude that, in repealing former sections 4663, 4750, and 4750.5 and in adopting new sections 4663 and 4664(a), the Legislature intended to expand rather than narrow the scope of legally permissible apportionment. This legislative intent is established not only by its declaration in adopting SB 899, 8 but also by the language of section 4663 itself. That is, section 4663(c) provides for apportionment based on "what approximate percentage of the permanent disability was caused by *other factors both before and subsequent to the industrial injury, including prior* ***[*617]*** *industrial injuries.*" (Emphasis added.) The language stating that apportionment may [**31] be based on "other factors both before and subsequent to the industrial injury" does not limit what non-industrial factors may be considered as a cause of permanent disability purposes of apportionment. Thus, this language appears to require apportionment based on ***any*** "other [non-industrial] factor," either pre- or post-injury. Similarly, because section 4663(c) states that the non-industrial factors are ***inclusive*** of "prior industrial injuries," this language appears to reflect a legislative intent to enlarge the range of factors that may be considered in determining the cause of permanent disability. The word "including" is ordinarily a word of enlargement, not of limitation. (*Shell Oil Co. v. Winterthur Swiss*

Ins. Co. (1993) 12 Cal.App.4th 715, 749 [15 Cal. Rptr. 2d 815]; *Patricia J. v. Rio Linda Union Sch. Dist.* (1976) 61 Cal.App.3d 278, 286 [132 Cal. Rptr. 211]; *Estate of Johnson* (1970) 5 Cal.App.3d 173, 180 [84 Cal. Rptr. 914].)

Because the language of section 4663 does not limit the types of "other factors" that may be considered as a non-industrial cause of permanent disability, then the "other factors" may include disability that was apportionable prior to SB 899, i.e., the natural progression of a non-industrial condition or disease, a preexisting disability, or a post-injury disabling event. (See former §§4663, 4750, 4750.5.) In addition, the "other factors" now may include pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions, provided there is substantial medical evidence establishing that these other factors have caused permanent disability. 9 In this case, the issue is whether an apportionment of permanent disability can be made based on the preexisting arthritis in applicant's knees. Under pre-SB [**33] 899 apportionment law, there would have been a question of whether this would have **[*618]** constituted an impermissible apportionment to pathology or causative factors. (E.g., *Pullman Kellogg v. Workers' Comp. Appeals Bd. (Normand), supra,* 26 Cal.3d at pp. 454–455, 456 [at fn. 4]; *King v. Workers' Comp. Appeals Bd., supra,* 231 Cal.App.3d 1640, 1647 [56 Cal.Comp.Cases 408]; *Duthie v. Workers' Comp. Appeals Bd., supra,* 86 Cal.App.3d at p. 728.) Under SB 899, however, apportionment now can be based on non-industrial pathology, if it can be demonstrated by substantial medical evidence that the non-industrial pathology has caused permanent disability.

Accordingly, section 4663(a) and (c)—as well as section 4664(a)—give renewed viability to cases such as *Baker v. Industrial Acc. Com.* (1966) 243 Cal.App.2d 380 [52 Cal. Rptr. 276] [31 Cal.Comp.Cases 228]. [**35] In *Baker,* the injured employee's lung conditions, which had resulted in permanent total disability before apportionment, were caused both by industrial factors (asthma due to allergic reactions to wheat and rye flour at work) and non-industrial factors (including emphysema due to a 40-year history of smoking at least one pack of cigarettes a day). The Court of Appeal held that if an employee "suffers from a disability which derives from both industrial and non-industrial causes," then "[t]he employer is liable only for that part of the overall disability which is reasonably attributable to industrial causation." (*Baker v. Industrial Acc. Com., supra,* 243 Cal.App.2d at p. 390.) Thus, the Court approved a finding that the employee was entitled to only a 55% permanent disability award, after apportionment of 45% of the disability to the non-industrial causes.

Some 14 years later, the Supreme Court expressly disapproved of *Baker* because its apportionment to causation did not comport with subsequently developed legal principles of apportionment under former section 4663. (See *Pullman Kellogg v. Workers' Comp. Appeals Bd. (Normand), supra,* 26 Cal.3d at p. 456 [at fn. 4].) The Supreme Court [**36] implicitly suggested that, had *Baker* been decided under former 4663 using these principles, apportionment would not have been proper because it is the disability resulting from, rather than a cause of, a disease which is the proper subject of apportionment, and because there was no evidence in *Baker* that the employee's smoking would have caused any disability had he not been exposed to substances at work. (*Pullman Kellogg v. Workers' Comp. Appeals Bd. (Normand), supra,* 26 Cal.3d at pp. 454–455 & 456 [at fn. 5].)

However, old section 4663 was repealed by SB 899, and new section 4663 allows apportionment to causation, giving *Baker* and similar cases new life.

Applicant asserts that because SB 899 did not amend section 4751, relating to benefits payable by the Subsequent Injuries Benefits Trust Fund ("SIF"), this reflects a legislative intent that pathology is not one of the "other factors" upon which apportionment to non-industrial causes can be based. In essence, applicant asserts that if apportionment based on pathology were allowed, this would cause a flood of SIF benefit claims to be filed under section 4751. This is because, in applicant's view, apportionment to pathology would [**37] decrease the percentage of disability for **[*619]** which the employer is responsible, while the overall level of disability would remain unchanged, leaving the SIF responsible for the difference. We disagree.

The SIF is a state fund that, under limited statutorily specified conditions, provides benefits to employees with preexisting permanent disability who sustain subsequent industrial injuries resulting in additional permanent disability. (Lab. Code, § 4751.) The purpose of the SIF is both to encourage disabled persons to seek employment and to encourage employers to hire them. (*Ferguson v. Industrial Acc. Com.* (1958) 50 Cal.2d 469, 474–475 [326 P.2d 145] [23 Cal.Comp.Cases 108]); *Subsequent Injuries Fund v. Industrial Acc. Com. (Patterson)* (1952) 39 Cal.2d 83, 86 [244 P.2d 889]

[17 Cal.Comp.Cases 142].)

Under section 4751, the employee's preexisting disability may be industrial or nonindustrial in origin. (*Subsequent Injuries Fund v. Workmen's Comp. Appeals Bd. (Talcott)* (1970) 2 Cal.3d 56, 62 [465 P.2d 28, 84 Cal. Rptr. 140] [35 Cal.Comp.Cases 80].) Thus, the preexisting disability may arise from any source—congenital, developmental, pathological, or traumatic.

Nevertheless, to qualify [**38] for SIF benefits, the injured employee must meet the requirements of section 4751. (*Brown v. Workers' Comp. Appeals Bd.* (1970) 20 Cal.App.3d 903, 914 [98 Cal. Rptr. 96] [36 Cal.Comp.Cases 627].) And the chief requirement for SIF benefits is that the condition must have been "labor disabling" prior to the occurrence of the subsequent industrial injury. (*Ferguson v. Industrial Acc. Com.* (1958) 50 Cal.2d 469, 477 [326 P.2d 145] [23 Cal.Comp.Cases 108]; *Franklin v. Workers' Comp. Appeals Bd., supra,* 79 Cal.App.3d at pp. 237–238.) Accordingly, if an applicant's non-industrial pathology causes apportionable permanent disability under section 4663 or 4664(a), then SIF benefits will not be payable under section 4751 unless the applicant demonstrates that the pathology was causing permanent disability prior to the subsequent industrial injury. Although this may mean that, in some cases, an injured employee will not get either permanent disability benefits or SIF benefits for the apportioned disability, this is not a major change from pre-SB 899 law, which held that an injured employee was not entitled to SIF benefits based on an asymptomatic disease process that was not labor disabling prior [**39] to the industrial injury. (See *State of Cal. v. Industrial Acc. Com. (Bachrach)* (1957) 147 Cal.App.2d 818, 824 [306 P.2d 64] [22 Cal.Comp.Cases 17]; *Urquiza v. Industrial Acc. Com.* (1956) 144 Cal.App.2d 322, 324 [300 P.2d 871] [21 Cal.Comp.Cases 286]; *Subsequent Injuries Fund v. Industrial Acc. Com. (Strauss)* (1955) 135 Cal.App.2d 544, 551 [288 P.2d 31] [20 Cal.Comp.Cases 230].) 10 In any event, it is an issue within the Legislature's domain, not ours.

[*620]

E.

Even Where A Medical Report "Addresses" The Issue Of Causation Of The Permanent Disability And Makes An "Apportionment Determination" By Finding The Approximate Relative Percentages Of Industrial And Non-Industrial Causation Under Section 4663(a), The Report May Not Be Relied Upon Unless It Also Constitutes Substantial Evidence.

Section 4663 sets out [**40] various requirements for doctors' reports on the issue of apportionment, including that each report must "address" the issue of causation of the permanent disability and must make an "apportionment determination" by finding the approximate relative percentages of permanent disability directly caused by the industrial injury and that caused by other factors. 11 Nevertheless, the mere fact that a report "addresses" the issue of causation of the permanent disability and makes an "apportionment determination" by finding the approximate relative percentages of industrial and non-industrial causation does not necessarily render the report one upon which the WCAB may rely. This is because it is well established that any decision of the WCAB must be supported by substantial evidence. (Lab. Code, § 5952(d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274, 281 [520 P.2d 978, 113 Cal. Rptr. 162] [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312, 317 [475 P.2d 451, 90 Cal. Rptr. 355] [35 Cal.Comp.Cases 500]; *LeVesque v. Workmen's Comp. Appeals Bd.* (1970) 1 Cal.3d 627, 635 [463 P.2d 432, 83 Cal. Rptr. 208] [35 Cal.Comp.Cases 16].)

In this regard, it has been long established that, in order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability. (*McAllister v. Workmen's Comp. Appeals Bd.* (1968) 69 Cal.2d 408, 413, 416–417, 419 [445 P.2d 313, 71 Cal. Rptr. 697] [33 Cal.Comp.Cases 660]; *Travelers Ins. Co. v. Industrial Acc. Com. (Odello)* (1949) 33 Cal.2d 685, 687–688 [203 P.2d 747] [14 Cal.Comp.Cases 54]; [**42] *Rosas v. Workers' Comp. Appeals Bd.* (1993) 16 Cal.App.4th 1692, 1700–1702, 1705 [20 Cal. Rptr. 2d 778] [58 Cal.Comp.Cases 313].) Also, a medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess. (*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [480 P.2d 967, 93 Cal. Rptr. **[*621]** 15] [36 Cal.Comp.Cases 93]; *Place v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 372, 378–379 [475 P.2d 656, 90 Cal. Rptr. 424] [35 Cal.Comp.Cases 525]; *Zemke v. Workmen's Comp. Appeals Bd., supra,* 68 Cal.2d at p. 798.) Further, a medical report is not substantial evidence

unless it sets forth the reasoning behind the physician's opinion, not merely his or her conclusions. (*Granado v. Workers' Comp. Appeals Bd.* (1970) 69 Cal.2d 399, 407 [445 P.2d 294, 71 Cal. Rptr. 678] (a mere legal conclusion does not furnish a basis for a finding); *Zemke v. Workmen's Comp. Appeals Bd., supra,* 68 Cal.2d at pp. 799, 800–801 (an opinion that fails to disclose its underlying basis and gives a bare legal conclusion does not constitute substantial evidence); see [**43] also *People v. Bassett* (1968) 69 Cal.2d 122, 141, 144 [443 P.2d 777, 70 Cal. Rptr. 193] (the chief value of an expert's testimony rests upon the material from which his or her opinion is fashioned and the reasoning by which he or she progresses from the material to the conclusion, and it does not lie in the mere expression of the conclusion; thus, the opinion of an expert is no better than the reasons upon which it is based).)

Moreover, in the context of apportionment determinations, the medical opinion must disclose familiarity with the concepts of apportionment, describe in detail the exact nature of the apportionable disability, and set forth the basis for the opinion, so that the Board can determine whether the physician is properly apportioning under correct legal principles. (*Ashley v. Workers' Comp. Appeals Bd., supra,* 37 Cal.App.4th at pp. 326–327; *King v. Workers' Comp. Appeals Bd., supra,* 231 Cal.App.3d at pp. 1646–1647; *Ditler v. Workers' Comp. Appeals Bd., supra,* 131 Cal.App.3d at pp. 812–813.)

Thus, to be substantial evidence on the issue of the approximate percentages of permanent disability due to the direct results of the injury and the approximate percentage of permanent [**44] disability due to other factors, a medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions.

For example, if a physician opines that approximately 50% of an employee's back disability is directly caused by the industrial injury, the physician must explain how and why the disability is causally related to the industrial injury (e.g., the industrial injury resulted in surgery which caused vulnerability that necessitates certain restrictions) and how and why the injury is responsible for approximately 50% of the disability. 12 And, if a physician opines that 50% of an employee's back disability is caused by degenerative disc disease, the physician must explain the nature of the degenerative disc disease, how and why it is causing permanent disability at the time of the evaluation, and how and why it is responsible for approximately 50% of the disability.

[*622]

III.

Application Of These Principles To The Present Case

Here, in opining under section 4663 that 50% of applicant's permanent disability was caused by "other factors" consisting of preexisting degenerative arthritis in both knees, the WCJ relied upon the apportionment determination of defendant's QME, Dr. Ovadia.

As discussed above, Dr. Ovadia opined that there is a "medically reasonable" basis for apportionment: (1) because of the "trivial nature" of applicant's October 28, 2002 left knee injury; (2) because of the almost immediate onset of right knee symptoms after that injury; and (3) because of the "obvious, significant degenerative arthritis in both knees" reflected in a pre-surgical MRI of applicant's left knee taken shortly after her October 28, 2002 injury and reflected in post-surgical x-rays. Dr. Ovadia also stated, "it is medically probable that she would have had fifty percent of her current level of knee disability at the time of today's evaluation even in the absence of her employment at Marshalls."

The WCJ was justified in [**46] concluding that Dr. Ovadia's opinion meets the standards of section 4663 and that it is substantial evidence. That is, it appears that Dr. Ovadia based his opinion on an adequate medical history, examination, and facts, and applicant's petition does not contend otherwise. Also, Dr. Ovadia's opinion is not speculative, and it sets forth the reasoning behind his conclusions. Further, he states his apportionment opinion in terms of reasonable medical probability. Moreover, he assesses the relative percentages of industrial and non-industrial causation based on the time of his evaluation of applicant. Finally, he makes his apportionment determination by finding the approximate percentage of permanent disability caused by "other factors," i.e., her preexisting degenerative arthritis in both knees. (Dr. Ovadia's finding that approximately 50% of applicant's

permanent disability was caused by non-industrial factors necessarily implies a finding that 50% of her permanent disability was directly caused by the industrial injury.)

We recognize that Dr. Ovadia's March 15, 2004 report pre-dated the April 19, 2004 enactment of SB 899. Nevertheless, where a medical report is substantial evidence [**47] and meets all of the standards of section 4663, a WCJ or the Appeals Board may rely on it, even if it issued before SB 899's effective date.

Accordingly, we will affirm the WCJ's June 29, 2004 determination that applicant's bilateral knee injury entitles her to a 27% permanent disability award, because 50% of her permanent disability was caused by the preexisting non-industrial degenerative arthritis in both knees.

For the foregoing reasons,

IT IS ORDERED, as the Decision After Reconsideration of the Board (En Banc), that the Findings and Award issued by the workers' compensation administrative law judge on June 29, 2004, be, and it is hereby, **AFFIRMED**.

[*623]

WORKERS' COMPENSATION APPEALS BOARD (EN BANC)

Merle C. Rabine, Chairman

William K. O'Brien, Commissioner

James C. Cuneo, Commissioner

Janice J. Murray, Commissioner

Frank M. Brass, Commissioner

Ronnie G. Caplane, Commissioner

Footnotes

1 All further statutory references are to the Labor Code, unless otherwise specified.

2 Applicant's petition for reconsideration [**6] captions both Case No. GRO 00029816 (i.e., the October 28, 2002 bilateral knee injury) and Case No. GRO 00029817 (a claimed April 2003 through June 4, 2003 cumulative injury to her right knee). In Case No. GRO

00029817, however, the WCJ found that applicant's right knee injury related solely to her October 28, 2002 specific injury, and he ordered that applicant take nothing in the cumulative injury case. Applicant's petition raises no contentions with respect to the claimed cumulative right knee injury.

3 The Appeals Board's en banc decisions are binding precedent on all Appeals Board panels and WCJs. (Cal. Code Regs., tit. 8, § 10341; *City of Long Beach v. Workers' Comp. Appeals Bd. (Garcia)* (2005) 126 Cal.App.4th 298, 313, fn. 5 [23 Cal. Rptr. 3d 782] [70 Cal.Comp.Cases 109]; *Gee v. Workers' Comp. Appeals Board* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [118 Cal. Rptr. 2d 105] [67 Cal.Comp.Cases 236]; see also Govt. Code, § 11425.60(b).)

4 *Kleemann* implicitly overruled the WCAB's en banc decision in *Scheftner v. Rio Linda School Dist.* (2004) 69 Cal. Comp. Cases 1281 [Appeals Board en banc opinion], [**13] to the extent that *Scheftner* held that submission orders and orders closing discovery, which issued prior to the enactment of SB 899, are "existing" orders that cannot be reopened due to the prohibition set forth in Section 47 of SB 899. The Appeals Board, of course, must follow *Kleemann* under the principle of stare decisis. (*Auto Equity Sales v. Superior Court* (1962) 57 Cal.2d 450, 455 [369 P.2d 937, 20 Cal. Rptr. 321].)

5 Section 4663(c) refers to permanent disability "caused by the direct result of [the] injury," while section 4664(a) refers to permanent disability "directly caused by the injury." We see no significant difference in the meaning of these phrases and we will treat them as being the same.

6 See also *Fresno Unified School Dist. v. Workers' Compensation Appeals Bd. (Humphrey)* (2000) 84 Cal.App.4th 1295, 1304 [101 Cal. Rptr. 2d 569] [65 Cal.Comp.Cases 1232]; *Ashley v. Workers' Comp. Appeals Bd.* (1995) 37 Cal.App.4th 320, 326 [43 Cal. Rptr. 2d 589] [60 Cal.Comp.Cases 683]; *Calhoun v. Workers' Comp. Appeals Bd.* (1981) 127 Cal.App.3d 1, 8 [179 Cal. Rptr. 198] [46 Cal.Comp.Cases 1333].) *Robinson v. Workers' Comp. Appeals Bd.* (1981) 114 Cal.App.3d 593, 603 [171 Cal. Rptr. 48] [46 Cal.Comp.Cases 78].

7 The last paragraph of section 5500.5(a) also precludes the apportionment of permanent disability to any prior, uncompensated cumulative [**25] industrial trauma in a cumulative

injury case. (*County of Los Angeles v. Workers' Comp. Appeals Bd. (Russell)* (1987) 52 Cal.Comp.Cases 395 (writ den.); *The Burbank Studios v. Workers' Comp. Appeals Bd. (Hannifin)* (1980) 45 Cal.Comp.Cases 670 (writ den.); *Hartford Accident and Indemnity Co. v. Workers' Comp. Appeals Bd. (Barrett)* (1978) 43 Cal.Comp.Cases 858 (writ den.); see also *Flesher v. Workers' Comp. Appeals Bd.* (1979) 23 Cal.3d 322, 324–327 [590 P.2d 35, 152 Cal. Rptr. 459] [44 Cal.Comp.Cases 212] (although section 5500.5 limits the defendants who are liable for compensation, it does not limit the beginning date of the cumulative trauma for which the employee can plead and recover); *Rielli v. Workers' Comp. Appeals Bd.* (1982) 134 Cal.App.3d 721, 725, fn. 3 [184 Cal. Rptr. 825] [47 Cal.Comp.Cases 828] (same).) Section 5500.5(a) was not affected by SB 899. Although it still exists, it is not relevant to our present discussion.

8

SB 899 stated: "This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity [**32] are [P] In order to provide relief to the state from the effects of the current workers' compensation crisis at the earliest possible time, it is necessary for this act to take effect immediately." (Stats. 2004, ch. 34, § 49; see also *Green v. Workers' Comp. Appeals Bd.* (2005) 127 Cal. App. 4th 1426 [70 Cal. Comp. Cas 294] [2005 Cal. App. LEXIS 504, 2005 WL 714881, 6.)]

9

We are aware of the principle that the employer takes the employees as it finds him or her, and that a person suffering from a preexisting disease or condition who is disabled by an industrial injury is entitled to compensation, even though the injury would not have adversely affected a normal person. (E.g., *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274, 282 [520 P.2d 978, 113 Cal. Rptr. 162] [39 Cal.Comp.Cases 210]; *Zemke v. Workmen's Compensation Appeals Bd., supra,* 68 Cal.2d at pp. 796, 800; *Berry v. Workmen's Comp. Appeals Bd.* (1968) 68 Cal.2d 786, 793 [441 P.2d 908, 69 Cal. Rptr. 68] [33 Cal.Comp.Cases 352]; [**34] *Colonial Ins. Co. v. Industrial Acc. Com. (Pedroza)* 29 Cal.2d 79, 83–84 [172 P.2d 884] [11 Cal.Comp.Cases 266]; *Tanenbaum v. Industrial Acc. Com.* (1935) 4 Cal.2d 615, 617–618 [52 P.2d 215] [20 I.A.C. 390].) Accordingly, under pre-SB 899 law, to the extent that a subsequent industrial injury exacerbated, accelerated, aggravated, or "lit up" an applicant's preexisting condition, the employer was liable for the resulting disability, without apportionment. (E.g., *Zemke v. Workmen's Comp. Appeals Bd., supra,* 68 Cal.2d at p. 796; *Berry v. Workmen's Comp. Appeals Bd., supra,* 29 Cal.2d at pp. 789–780 [*sic*]; *Colonial Ins. Co. v. Industrial Acc. Com. (Pedroza), supra,* 29 Cal.2d at pp. 83–84; *Tanenbaum v. Industrial Acc. Com., supra,* 4 Cal.2d at pp. 617–618.) In this case, however, there is no assertion that applicant's preexisting arthritis was exacerbated or accelerated by her industrial injury. Accordingly, we need not and will not now address the continuing the validity of these principles in light of new sections 4663 and 4664(a).

10 *Bachrach, Urquiza,* and *Strauss* were all disapproved on other grounds by *Subsequent Injuries Fund v. Industrial Acc. Com. (Allen), supra,* 56 Cal.2d at p. 846, and by *Ferguson v. Industrial Acc. Com., supra,* 50 Cal.2d at pp. 473, 479 (i.e., the Supreme Court held that proof of knowledge of the previous disability by the employee or the employer is not a prerequisite to SIF benefits).

11 Present section 4663 [**41] requires the apportionment of permanent disability caused by other factors, both before *and subsequent to* the industrial injury. (Lab. Code, § 4663(a) & (c); see also § 4664(a).) Accordingly, a physician's determination of the approximate percentages of industrial and non-industrial causation of permanent disability is to be based on the employee's condition *as of the time of the physician's examination* (provided that the industrial component of the disability is permanent and stationary). Therefore, requirements under former sections 4663 and 4750 regarding when the apportionable permanent disability had to exist or occur and regarding how the reporting physician had to frame and phrase the apportionment issue (see Section II-D, at 12:6–12:21 & 13:8–13:13 [70 Cal. Comp. Cas 614–615, *supra*) are no longer controlling or dispositive.

12 A physician cannot make an arbitrary percentage finding simply because it is "fair" in a particular case. (Cf. *Zemke v. Workmen's Comp. Appeals Bd., supra,* 68 Cal.2d at pp. 798, 800; [**45] *Berry v. Workmen's Comp. Appeals Bd., supra,* 68 Cal.2d at pp. 790–791; *Callahan v. Workers' Comp. Appeals Bd., supra,* 85 Cal.App.3d at p. 630.)

Content Type: Administrative Materials

Terms: 70 Cal. Comp. Cases 604

Narrow By: -None-

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City of Jackson v. Workers' Comp. Appeals Bd., 11 Cal. App. 5th 109

Copy Citation

Reporter

11 Cal. App. 5th 109 * 216 Cal. Rptr. 3d 911 ** 82 Cal. Comp. Cases 437 *** 2017 Cal. App. LEXIS 383 ****

CITY OF JACKSON, Petitioner, v. WORKERS' COMPENSATION APPEALS BOARD and CHRISTOPHER RICE, Respondents.

Subsequent History: Rehearing Denied by Court of Appeal May 18, 2017; Review Denied August 9, 2017

Time for Granting or Denying Hearing Extended City of Jackson v. Workers' Comp. Appeals Bd. & Christopher Rice, 2017 Cal. LEXIS 5383 (Cal., July 19, 2017)

Review denied by City of Jackson v. Workers' Comp. Appeals Bd. & Christopher Rice, 2017 Cal. LEXIS 6151 (Cal., Aug. 9, 2017)

Prior History: [****1] W.C.A.B. No. ADJ8701016—WCJ Joseph S. Samuel (SAC); W.C.A.B. Panel: Chairwoman Caplane, Commissioner Lowe, Deputy Commissioner Gondak [see Rice v. City of

Jackson, 2015 Cal. Wrk. Comp. P.D. LEXIS 57 (Appeals Board noteworthy panel decision)]

Disposition: Original proceedings to review a decision of the Workers' Compensation Appeals Board. *Writ of review issued, WCAB's decision annulled,* matter *remanded* with directions, and *costs awarded* to petitioner.

Core Terms

apportionment, disability, genetics, disease, degenerative, causation, activities, factors, apportioned, cervical, permanent disability, nonindustrial, preexisting, studies, personal history, Cases, medical evidence, applicant's, causes, reconsideration, heredity, degenerative disease, industrial, repetitive, diagnosis, pathology, medical probability, impermissible, heritability, neck

Case Summary

Overview

HOLDINGS: [1]-Apportionment of permanent disability in a workers' compensation case may be properly based on genetics or hereditability; [2]-A qualified medical evaluator (QME) properly apportioned an employee's disability when she concluded his disability, i.e., his debilitating neck, arm, hand, and shoulder pain preventing him from performing his job activities, was caused only partially (17 percent) by his work activities, and was caused primarily (49 percent) by his genetics; [3]-The QME's combined reports sufficed as substantial medical evidence to justify apportioning 49 percent of the employee's disability to non-industrial factors, as her diagnosis was based on medical history, physical examination, and diagnostic studies, and her conclusion was based on published medical studies that were cited in her report, in addition to an adequate medical history and examination.

Outcome

California Workers' Compensation Appeals Board's order anulled and matter remanded.

▼ LexisNexis® Headnotes

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review >

Standards of Review

Workers' Compensation & SSDI > ... > Judicial Review > Standards of Review >

Substantial Evidence

HN1 **Judicial Review, Standards of Review**
An appellate court reviews the California Workers' Compensation Appeals Board's factual findings for substantial evidence, but the court reviews its legal decisions de novo. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations >

Cumulative & Successive Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

HN2 **Benefit Determinations, Cumulative & Successive Disabilities**
Since the enactment of Senate Bill No. 899 (2003-2004 Reg. Sess.), apportionment of permanent disability is based on causation, and the employer is liable only for the percentage of permanent disability directly caused by the industrial injury. Apportionment may be based on *other factors that caused the disability, including the natural progression of a non-industrial* condition or disease, a preexisting disability, or a post-injury disabling event, pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions. Precluding apportionment based on impermissible immutable factors would preclude apportionment based on the very factors that the legislation now permits, i.e., apportionment based on pathology and asymptomatic prior conditions for which the worker has an inherited predisposition. There is no relevant distinction between allowing apportionment based on a preexisting congenital or pathological condition and allowing apportionment based on a preexisting degenerative condition caused by heredity or genetics. More like this Headnote

Shepardize - Narrow by this Headnote

Civil Procedure > Appeals > Amicus Curiae

HN3 **Appeals, Amicus Curiae**
Amicus curiae must accept the issues made and propositions urged by the appealing parties, and any additional questions presented in a brief filed by an amicus curiae will not be

considered. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Compensability > Arising Out of Employment > Causation

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

HN4 **Arising Out of Employment, Causation**
Lab. Code, § 4663, subd. (a), provides that apportionment of permanent disability must be based on causation. Causation in this context means causation of the permanent disability. The California Workers' Compensation Appeals Board has stated that the percentage to which an applicant's injury is causally related to his or her employment is not necessarily the same as the percentage to which an applicant's permanent disability is causally related to his or her injury.
More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

HN5 **Benefit Determinations, Permanent Partial Disabilities**
"Disability" as used in the workers' compensation context includes two elements: (1) actual incapacity to perform the tasks usually encountered in one's employment and the wage loss resulting therefrom, and (2) physical impairment of the body that may or may not be incapacitating. Permanent disability is the irreversible residual of an injury, and permanent disability payments are intended to compensate for physical loss and loss of earning capacity.
More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > Cumulative & Successive Disabilities

Workers' Compensation & SSDI > ... > Evidence > Admissibility of Evidence > Medical Evidence

HN6 **Benefit Determinations, Cumulative & Successive Disabilities**
Substantial evidence is relevant evidence a reasonable mind might accept as adequate to support a conclusion. The California Workers' Compensation Appeals Board has opined that in order for a medical opinion to constitute substantial evidence, it must be predicated on reasonable medical probability. It must also set forth the reasoning behind the physician's opinion. In the context of an apportionment determination, the opinion must disclose familiarity with the concepts of apportionment, describe in detail the exact nature of the apportionable disability, and set forth the basis for the opinion, so that the Board can determine whether the physician is properly apportioning under correct legal principles. A medical opinion must be framed in terms of reasonable medical probability, must not be speculative, must be based on pertinent facts and on adequate examination and history, and must set forth the reasoning in support of its conclusions. A medical report is not substantial medical evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess. More like this Headnote

Shepardize - Narrow by this Headnote

▼ Headnotes/Syllabus

Summary

[*109] CALIFORNIA OFFICIAL REPORTS SUMMARY

In a workers' compensation proceeding involving a city employee, the Workers' Compensation Appeals Board disregarded the apportionment determination of the qualified medical evaluator (QME) on the ground the determination was not substantial medical evidence and directed the workers' compensation administrative law judge to make an award of unapportioned disability. The QME had concluded that the employee's disability—neck, shoulder, arm, and hand pain—was caused by cervical degenerative disc disease, and that the disease, in turn, was caused in large part by heredity or genetics. The QME thus had assigned causation 49 percent to the employee's personal history, which included, but was not limited to, the genetic cause of the degenerative disease.

The Court of Appeal annulled the board's order and remanded the matter. The court held that apportionment may be properly based on genetics or hereditability. The court saw no relevant distinction between apportionment for a preexisting disease that is congenital and degenerative, and apportionment for a preexisting degenerative disease caused by heredity or genetics. Contrary to the board's opinion, the QME properly apportioned disability because she did not apportion causation to injury rather than disability. The QME's reports reflected, without speculation, that the employee's disability was the result of cervical radiculopathy and degenerative disc disease. Her diagnosis was based on medical history, physical examination, and diagnostic studies that included X-rays and magnetic resonance imaging scans. The QME determined that 49 percent of the employee's condition was caused by heredity, genomics, and other personal history factors. Her conclusion was based on published medical studies that were cited in her report, in addition to an adequate medical history and examination. The QME's combined reports were more than sufficient to meet the standard of substantial medical evidence. (Opinion by Blease, Acting P. J., with Hoch and Renner, JJ., concurring.)

Headnotes

CALIFORNIA OFFICIAL REPORTS HEADNOTES

CA(1) **(1) Workers' Compensation § 106—Permanent Disability—Apportionment—Causation—Heredity or Genetics.**

Since the enactment of Senate Bill No. 899 (2003–2004 Reg. Sess.), apportionment of permanent disability is based on causation, and the employer is liable only for the percentage of permanent disability directly caused by the industrial injury. Apportionment may be based on other factors that caused the disability, including the natural progression of a nonindustrial condition or disease, a preexisting disability, or a postinjury disabling event, pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions. Precluding apportionment based on impermissible immutable factors would preclude apportionment based on the very factors that the legislation now permits, i.e., apportionment based on pathology and asymptomatic prior conditions for which the worker has an inherited predisposition. There is no relevant distinction between allowing apportionment based on a preexisting congenital or pathological condition and allowing apportionment based on a preexisting degenerative condition caused by heredity or genetics.

CA(2) **(2) Workers' Compensation § 106—Permanent Disability—Apportionment—Causation.**

Lab. Code, § 4663, subd. (a), provides that apportionment of permanent disability must be based on causation. Causation in this context means causation of the permanent disability. The Workers' Compensation Appeals Board has stated that the percentage to which an applicant's injury is causally related to his or her employment is not necessarily the same as the percentage to which an applicant's permanent disability is causally related to his or her injury.

CA(3) **(3) Workers' Compensation § 2—Disability—Elements—Permanent.**

"Disability" as used in the workers' compensation context includes two elements: (1) actual incapacity to perform the tasks usually encountered in one's employment and the wage loss resulting therefrom, and (2) physical impairment of the body that may or may not be incapacitating. Permanent disability is the irreversible residual of an injury, and permanent disability payments are intended to compensate for physical loss and loss of earning capacity.

CA(4) **(4) Workers' Compensation § 106—Disability—Medical Opinion—Substantial Evidence—Apportionment Determination.**

Substantial evidence is relevant evidence a reasonable mind might accept as adequate to support a conclusion. The Workers' Compensation Appeals Board has **[*111]** opined that in

order for a medical opinion to constitute substantial evidence, it must be predicated on reasonable medical probability. It must also set forth the reasoning behind the physician's opinion. In the context of an apportionment determination, the opinion must disclose familiarity with the concepts of apportionment, describe in detail the exact nature of the apportionable disability, and set forth the basis for the opinion, so that the board can determine whether the physician is properly apportioning under correct legal principles. A medical opinion must be framed in terms of reasonable medical probability, must not be speculative, must be based on pertinent facts and on adequate examination and history, and must set forth the reasoning in support of its conclusions. A medical report is not substantial medical evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess.

CA(5) **(5) Workers' Compensation § 106—Disability—Medical Opinion—Substantial Evidence—Apportionment Determination—Heredity or Genetics.**

A qualified medical evaluator's reports reflected, without speculation, that an employee's disability was the result of cervical radiculopathy and cervical degenerative disc disease. Her diagnosis was based on medical history, physical examination, and diagnostic studies that included X-rays and magnetic resonance imaging scans. The qualified medical evaluator determined that 49 percent of the employee's condition was caused by heredity, genetics, and other personal history factors. Her conclusion was based on medical studies that were cited in her report, in addition to an adequate medical history and examination. The qualified medical evaluator's combined reports were more than sufficient to meet the standard of substantial medical evidence.

[Herlick, California Workers' Compensation Law (6th ed. 2016) ch. 7, § 7.40; Hanna, Cal. Law of Employee Injuries and Workers' Compensation Law (2017) ch. 8, § 8.06.]

▼ California Compensation Headnotes/Summary

Headnotes

Permanent Disability > Apportionment > Substantial Medical Evidence > Genetics

Court of Appeal, annulling WCAB's decision after reconsideration and remanding matter to WCAB with instructions to deny reconsideration, held that apportionment may be properly based on genetics/hereditability, that qualified medical evaluator properly apportioned applicant's permanent disability, and that her opinion was based on substantial medical evidence, when Court of Appeal found that applicant, while employed by defendant, incurred cumulative trauma injury AOE/COE to his neck, that qualified medical evaluator opined that applicant's post-neck surgery pain was caused, 17 percent each, by applicant's employment, by his previous employment, and by his personal activities, and 49 percent by his personal history, "including genetic issues," that in *Escobedo v. Marshalls* (2005) 80 Cal. Comp. Cases 604 (Appeals Board en banc opinion) WCAB held that SB 899 permits apportionment based on "the natural progression of a non-industrial condition or disease, a preexisting disability, or a post-injury disabling event, ... pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions," that precluding apportionment based on

"impermissible immutable factors," as argued by defendant in present case, would preclude apportionment based on "the very factors that the legislation now permits, i.e., apportionment based on pathology and asymptomatic prior conditions for which the worker has an inherited predisposition," that the Court of Appeal perceived "no relevant distinction between allowing apportionment based on a preexisting congenital or pathological condition and allowing apportionment based on a preexisting degenerative condition caused by heredity or genetics," that qualified medical evaluator properly apportioned causation of applicant's disability rather than, as stated in WCAB's opinion, on causation of applicant's injury, and that qualified medical evaluator's apportionment was based on substantial medical evidence.

[See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.05[1], [2][a], 8.06[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.40[2], [3], 7.41[3].]

Counsel: Lenahan, Lee, Slater & Pearse and Charles S. Templeton for Petitioner.

Finnegan, Marks, Theofel & Desmond and Ellen Sims Langille for California Chamber of Commerce as Amicus Curiae on behalf of Petitioner. **[*112] [*112]**

Mastagni Holstedt, Eric D. Ledger and Edward W. Lester for Respondent Christopher Rice. [***438]

No appearance for Respondent Workers' Compensation Appeals Board.

William A. Herreras for California Applicants' Attorneys Association as Amicus Curiae on behalf of Respondent Christopher Rice.

Judges: Opinion by Blease, Acting P. J., with Hoch and Renner, JJ., concurring.

Opinion by: Blease, Acting P.J.

Opinion

[**912] **BLEASE, Acting P. J.**—In this workers' compensation proceeding we granted the writ of review of the employer, City of Jackson (City), after the Workers' Compensation Appeals Board (Board) disregarded the apportionment determination of the qualified medical evaluator (QME) on the ground the determination [**913] was not substantial medical evidence and directed the workers' compensation administrative law judge (ALJ) to make an award of unapportioned disability.

[***439]

The QME concluded that the employee's disability—neck, [****2] shoulder, arm, and hand pain—was caused by cervical degenerative disc disease, and that the disease, in turn, was caused in large part

by heredity or genetics. The QME thus assigned causation 49 percent to the employee's personal history, which included, but was not limited to, the genetic cause of the degenerative disease. The ALJ agreed with the QME's apportionment, but the Board did not.

The Board concluded the QME could not assign causation to genetics because that is an "impermissible immutable factor[]." The Board also concluded that by relying on the employee's genetic makeup, the QME apportioned the causation of the injury rather than the extent of his disability. Finally, the Board concluded the QME's determination was not substantial medical evidence.

We disagree with each of the Board's conclusions, and shall annul its order and remand with directions to deny reconsideration.

FACTUAL AND PROCEDURAL BACKGROUND

Christopher Rice worked for the City as a police officer. He started employment with City as a reserve officer in August 2004, and became full time in 2005. He sustained injury to his neck arising out of and in the course of his employment during the cumulative period ending [****3] April 22, 2009, at which time Rice was 29 years old.

[*113] [*113]

Before undergoing neck surgery, Rice was examined by QME Dr. Sloane Blair in November 2011. Dr. Blair examined Rice and reviewed his medical records. Rice's injury was cumulative, i.e., he had not suffered an exact or isolated injury.[1] Rice and his treating physician believed his pain was a consequence of repetitive bending and twisting of his head and neck.

An X-ray showed degenerative disc disease. Dr. Blair diagnosed Rice with cervical radiculopathy and cervical degenerative disc disease.[2]

As is relevant to the issue of apportionment, Dr. Blair found Rice's condition was caused by (1) his work activities for the City; (2) his prior work activities; (3) his personal activities, including prior injuries and recreational activities; and (4) his personal history, in which category Blair included "heritability and genetics," Rice's "history of smoking," and "his diagnosis of lateral epicondylitis [commonly known as tennis elbow]." Dr. Blair apportioned each factor equally at 25 percent.

Dr. Blair reevaluated Rice in May 2013 following his neck surgery. Her diagnosis was unchanged and the four causes contributing to the diagnosis were [****4] [***440] unchanged, but the apportionment was changed. Dr. Blair stated, "Since his evaluation on 11.7.11, there are specific publications that have lent even more support to the causation of genomics/genetics/heritable issues in terms of his injury." Dr. Blair listed three such studies, and stated that because [**914] more recent studies supported "genomics as a significant causative factor in cervical spine disability," her apportionment changed to 17 percent each to Rice's employment with City, previous employment, and personal activities, and 49 percent to his personal history, "including genetic issues."

In response to questions from Rice's attorney, Dr. Blair prepared a supplemental report, in which she affirmed that she could state "to a reasonable degree of medical probability that genetics has played a role in Mr. Rice's injury," despite the fact that there is no way to test for genetic factors. Citing to the referenced medical studies, Dr. Blair stated that one of them said "heritability was ... 73 percent in the cervical spine. ... [S]moking, age, and work are only a small percentage of disc disease and most of it is familial." Another source cited the role of heritability in disc degeneration [****5] as 75 percent, and the other stated it was 73 percent. Dr. Blair **[*114] [*114]** cited a fourth article that claimed, "'[t]win studies demonstrate that degeneration in adults may be explained up to 75 percent by genes alone.'" The same study found environmental factors to contribute little or not at all. Dr. Blair stated that while these studies supported an apportionment of 75 percent to personal history, she decided to err on the side of the patient in case there was some unknown "inherent weakness" in the study, and decided that 49 percent was the "lowest level that could reasonably be stated." Dr.

Blair stated that even without knowing the cause of Rice's father's back problems, the evidence of Rice's degenerative disc disease having a predominantly genetic cause was "fairly strong" where there is no clear traumatic injury, as in Rice's case.

The ALJ found that Dr. Blair did not provide "sufficient information to identify the nature of any prior cervical problems and 'how and why' any such problems are related to applicant's current level of permanent disability." Accordingly, the ALJ concluded that Dr. Blair's apportionment of 17 percent to prior work activities and 17 percent to prior activities was not [****6] based on substantial evidence. This conclusion is not part of this writ proceeding. The ALJ further found City had carried its burden of showing apportionment as to 49 percent attributable to genetic factors, and this is the determination at issue here.

Rice filed a petition for reconsideration before the Board, arguing that the 49 percent apportionment to genetic risk factors was not substantial medical evidence because there was no evidence Rice's family had a history of cervical degenerative disc disease, and there was no genetic test for degenerative disc disease. The Board granted the petition for reconsideration and eventually ordered the matter returned to the trial level for an unapportioned award of permanent disability. The Board reasoned that "finding causation on applicant's 'genetics' opens the door to apportionment of disability to impermissible immutable factors. ... Without proper apportionment to specific identifiable factors, we cannot rely upon Dr. Blair's determination as substantial medical evidence to justify apportioning 49% of applicant's disability to non-Industrial factors."

[***441]

DISCUSSION

I

Standard of Review

HN1 We review the Board's factual findings for substantial [****7] evidence, but we review its legal decisions de novo. (**[*115]** *Department of Rehabilitation v. Workers' Comp. Appeals Bd.* (2003) 30 Cal.4th 1281, 1298 [135 Cal. Rptr. 2d 665, **[*115]** 70 P.3d 1076]; *Le Vesque v. Workers' Comp. Appeals Bd.* (1970) 1 Cal.3d 627, 637 [83 Cal. Rptr. 208, 463 P.2d 432].) [**915] This case turns on the Board's legal decisions.

II

Apportionment May Be Properly Based on Genetics/Hereditability

The Board opined without explanation that apportioning causation to "'genetics' opens the door to apportionment of disability to impermissible immutable factors." We perceive no impermissible apportionment here, and the Board's prior apportionment decisions under similar circumstances belies the validity of its statement.

Prior to 2004, when the Legislature enacted Senate Bill No. 899 (2003–2004 Reg. Sess.), apportionment based on causation was prohibited. (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1326 [57 Cal. Rptr. 3d 644, 156 P.3d 1100] (*Brodie*).) A disability that resulted from both industrial and nonindustrial causes was apportionable only if the nonindustrial portion would have resulted from the normal progression of the nonindustrial disease. (*Ibid.*) This meant employers

were liable for the entire disability if the disability arose in part from an interaction between an industrial cause and a nonindustrial cause, but the nonindustrial cause alone would not have given rise to a disability. (*Ibid.*) Thus, an employer was liable for the entire disability if an industrial injury aggravated a previously [****8] existing nonindustrial condition. (*Ibid.*)

For example, in *Zemke v. Workmen's Comp. App. Bd.* (1968) 68 Cal.2d 794, 796 [69 Cal. Rptr. 88, 441 P.2d 928] (*Zemke*), the worker suffered an injury to his back when he lifted a barrel at work. Three doctors agreed that the worker had a preexisting "arthritic condition" that was asymptomatic before the injury. (*Id.* at p. 797.) The doctors variously described the preexisting condition as osteoarthritic changes and degenerative disc disease. (*Id.* at pp. 797–798.) The Board, following the doctors' opinion on apportionment, found that 50 percent of the worker's disability was attributable to the preexisting condition. (*Id.* at p. 797.) The Supreme Court annulled the Board's ruling, holding that, "'the employer takes the employee subject to his condition when he enters the employment, and that therefore compensation is not to be denied merely because the workman's physical condition was such as to cause him to suffer a disability from an injury which ordinarily, given a stronger and healthier constitution, would have caused little or no inconvenience.'" (*Id.* at p. 800.) *Zemke* was [***442] superseded by the enactment of Senate Bill No. 899 (2003–2004 Reg. Sess.). (*Brodie, supra*, 40 Cal.4th at p. 1326.)

[*116] [*116]

CA(1) **(1)** *HN2* Since the enactment of Senate Bill No. 899 (2003–2004 Reg. Sess.), apportionment of permanent disability is based on causation, and the employer [****9] is liable only for the percentage of permanent disability directly caused by the industrial injury. (*Brodie, supra*, 40 Cal.4th at pp. 1324–325.) Apportionment may now be based on "'other factors'" that caused the disability, including "the natural progression of a non-industrial condition or disease, a preexisting disability, or a post-injury disabling event[,] ... pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions ... ." (*Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 617–618 (*Escobedo*).) Precluding apportionment based on "impermissible immutable factors" would preclude apportionment based on the very factors that the legislation now permits, i.e., apportionment based on pathology and [**916] asymptomatic prior conditions for which the worker has an inherited predisposition.

The Board's ruling indicates that it believes "genetics" is not a proper factor on which to base causation. However, since 2004 it has allowed apportionment based on such a factor, even though it may not have used the term "genetics."

In *Kos v. Workers' Comp. Appeals Bd.* (2008) 73 Cal.Comp.Cases 529, 530 (*Kos*) the worker developed back and hip pain while working as an office manager. She was diagnosed with "multilevel degenerative disease," and the medical evaluator found that the underlying degenerative disc disease was not caused by work activities, [****10] but that the worker's prolonged sitting at work "'lit up'" her preexisting disc disease. (*Id.* at pp. 530, 531.) The medical evaluator testified that the worker's "pre-existing genetic predisposition for degenerative disc disease would have contributed approximately 75 percent to her overall level of disability." (*Id.* at p. 531.) Nevertheless, the ALJ found no basis for apportioning the disability. (*Id.* at p. 532.) The Board granted reconsideration and rescinded the ALJ decision. (*Id.* at p. 532.) The Board stated that in degenerative disease cases, it is incorrect to conclude that the worker's permanent disability is necessarily entirely caused by the industrial injury without apportionment. (*Id.* at p. 533.) Thus, in *Kos*, the Board had no trouble apportioning disability where the degenerative disc disease was caused by a "pre-existing genetic predisposition." (*Id.* at p. 531.)

In *Escobedo, supra*, 70 Cal.Comp.Cases at pages 608, 609, the ALJ apportioned 50 percent of the worker's knee injury to nonindustrial causation based on the medical evaluator's opinion that the worker suffered from """significant degenerative arthritis."" The Board stated: "In this case, the issue is whether an apportionment of permanent disability can be made based on the preexisting arthritis in applicant's knees. Under pre-[Senate Bill No.] [****11] 899 [(2003–2004 Reg. Sess.)] apportionment law, there would have been a **[*117] [*117]** question of whether this would have constituted an impermissible apportionment to pathology or causative factors. [Citations.] Under [Senate Bill No.] 899 [(2003–2004 Reg. Sess.)], however, apportionment now can be based on non-industrial pathology, if it can be [***443] demonstrated by substantial medical evidence that the non-industrial pathology has caused permanent disability. [¶] ... [¶] ... Thus, the preexisting disability

may arise from any source—congenital, developmental, pathological, or traumatic." (*Id.* at pp. 617–619.) We perceive no relevant distinction between allowing apportionment based on a preexisting congenital or pathological condition and allowing apportionment based on a preexisting degenerative condition caused by heredity or genetics.

In *Acme Steel v. Workers' Comp. Appeals Bd.* (2013) 218 Cal.App.4th 1137, 1139 [160 Cal. Rptr. 3d 712], the medical examiner apportioned 40 percent of the worker's hearing loss to "'congenital degeneration'" of the cochlea. (*Id.* at p. 1139.) The ALJ nevertheless refused to apportion the disability, and the Board denied the employer's petition for reconsideration. (*Id.* at pp. 1140–1141.) The Court of Appeal granted the employer's writ of review and remanded the matter to the Board, holding Labor Code sections 4663 and 4664 required apportionment [****12] for the nonindustrial cause due to congenital degeneration where substantial medical evidence showed 100 percent of the hearing loss could not be attributed to the industrial cumulative trauma. (*Acme Steel*, at pp. 1142–1143.) Again, we see no relevant distinction between apportionment for a preexisting disease that is congenital and degenerative, and apportionment [**917] for a preexisting degenerative disease caused by heredity or genetics.[3]

III

Dr. Blair Properly Apportioned Disability

The Board's opinion stated: "[R]elying upon applicant's genetic makeup leads Dr. Blair to apportion the causation of applicant's injury rather than **[*118] [*118]** apportionment of the extent of his disability." The facts of this case do not support the Board's legal conclusion.

HN4 ***CA(2)*** **(2)** Labor Code section 4663, subdivision (a) provides: "Apportionment of permanent disability shall be based on causation." In *Escobedo, supra*, 70 Cal.Comp.Cases at page 611, the Board came to the obvious conclusion that causation in this context means causation of the permanent disability. The Board stated that "the percentage to which an applicant's *injury* is causally related to his or her employment is not necessarily the same as the percentage to which an [***444] applicant's *permanent disability* is causally related to his or her injury." (*Ibid.*)[4] While this might be true, Dr. Blair's [****13] analysis was not mistaken in this case.

HN5 ***CA(3)*** **(3)** "Disability" as used in the workers' compensation context includes two elements: "(1) actual incapacity to perform the tasks usually encountered in one's employment and the wage loss resulting therefrom, and (2) physical impairment of the body that may or may not be incapacitating." (*Allied Compensation Ins. Co. v. Industrial Acc. Com.* (1963) 211 Cal.App.2d 821, 831 [27 Cal. Rptr. 918].) Permanent disability is "'"the irreversible residual of an injury,"'" and permanent disability payments are intended to compensate for physical loss and loss of earning capacity. (*Brodie, supra*, 40 Cal.4th at p. 1320.) Here, Dr. Blair identified Rice's disability as neck pain and left arm, hand, and shoulder pain, which prevented him from sitting for more than two hours per day, lifting more than 15 pounds, and any vibratory activities such as driving long distances. All of these activities were included in Rice's job description.

Rice's *injury*, on the other hand, was a cumulative injury, which Dr. Blair stated Rice acknowledged was not an exact or isolated injury, but which he believed was a consequence of repetitive motion primarily resulting from his employment. Thus, the injury was repetitive motion. Dr. Blair did not conclude, as the Board apparently determined, that the repetitive motion [****14] (the injury) was caused by genetics. Rather, Dr. Blair properly concluded that Rice's *disability*, i.e., his debilitating neck, arm, hand, and shoulder pain preventing him from performing his job activities, was caused only partially (17 percent) by his [**918] work activities, and was caused primarily (49 percent) by his genetics. Contrary to the Board's opinion, Dr. Blair did not apportion causation to injury rather than disability.

[*119] [*119]

IV

Dr. Blair's Opinion Is Based on Substantial Medical Evidence

The Board found that Dr. Blair's report did not suffice as "substantial medical evidence to justify apportioning 49% of [Rice's] disability to non-industrial factors." We disagree.

HN6 ***CA(4)*** **(4)** Substantial evidence is relevant evidence a reasonable mind might accept as adequate to support a conclusion. (*Braewood Convalescent Hospital v. Workers' Comp. Appeals Bd.* (1983) 34 Cal.3d 159, 164 [193 Cal. Rptr. 157, 666 P.2d 14].) In *Escobedo, supra*, 70 Cal.Comp.Cases at page 620, the Board opined that in order for a medical opinion to constitute substantial evidence, it must be predicated on reasonable medical probability. It must also set forth the reasoning behind the physician's opinion. (*Id.* at p. 621.) In the context of an apportionment determination, the opinion must "disclose familiarity with the concepts of apportionment, describe in detail the exact nature of the apportionable [***445] disability, [****15] and set forth the basis for the opinion, so that the Board can determine whether the physician is properly apportioning under correct legal principles." (*Ibid.*) A medical opinion must be framed in terms of reasonable medical probability, must not be speculative, must be based on pertinent facts and on adequate examination and history, and must set forth the reasoning in support of its conclusions. (*Ibid.*) A medical report is not substantial medical evidence "if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess." (*Id.* at p. 620.)

Dr. Blair's diagnosis was that Rice's disability was the result of cervical radiculopathy and cervical degenerative disc disease. The apportionment determination that is relevant here is that part of the causation that Dr. Blair listed as "personal history." Dr. Blair initially apportioned 25 percent of the cause of disability to personal history. Her explanation was that studies indicate that heredity and genetics are significant causes of degenerative diseases of the spine, such as that exhibited by Rice. Dr. Blair also included in the personal history category [****16] Rice's history of smoking and previous diagnosis of lateral epicondylitis.

In a supplemental report, Dr. Blair stated that there is evidence in the literature that repetitive activity "has a link to degenerative disease." She stated that some of Rice's work activities could be associated "with work-related repetitive causation," thus work-related activities could not be eliminated as a potential cause.

[*120] [*120]

In a subsequent, postsurgical evaluation, Dr. Blair opined that the causes of Rice's disability remained the same, but the apportionment had changed. It changed because Dr. Blair became aware of three medical publications, which she named, that indicated the role of heredity in causing degenerative disc disease was greater than Dr. Blair previously realized. Because of these publications, Dr. Blair apportioned 49 percent of Rice's disability "to his personal history, including genetic issues, and 17 percent each to his employment with the City of Jackson, his previous employment history, and his personal injuries."

Dr. Blair attempted to explain her change of apportionment in a subsequent supplemental report. She was asked how she [**919] could state to a reasonable degree of medical probability that [****17] genetics played a role in Rice's injury. She responded that she could do so because medical studies showed that the role of "heritability" in degenerative disc disease had been found to be between 73 and 75 percent. One of the studies, which was conducted using twins, found: "'In comparison, suspected environmental factors were found to contribute little (e[.]g. physical loading, cigarette smoking, age[,] 2–7 percent variation) or not at all (e[.]g. whole body vibration associated with exposure to motor vehicle use).['] ... '[t]here is some variation with respect to the level of the spine, but the effects are small compared with the ability to predict degenerative changes based on family

data.'"

Dr. Blair stated that, given the medical literature, "... I think I can say to a reasonable degree of medical probability that genetics has played a role in Mr. Rice's injury. In fact, I think that your counterparts on the other side of this issue could come back to me and essentially say that I have not ascribed a significant [***446] enough percentage to that amount. However, I always try and err on the side of the patient. ... In my effort to err on the side of the patient, I decided against .63, .73, [****18] 73, 74, 75 percent because of perhaps some inherent weaknesses in the study, although I really do not know of any, and the fact that there are multiple sources does not really indicate any, but nevertheless, ... I decided on 49 percent as the lowest level that could reasonably be stated." Dr. Blair went on to say that even without researching Rice's family history, "the evidence is fairly strong that there is predominantly genetic causation, unless there is a clear traumatic injury, which, in Mr. Rice's case, there was not."

Rice incorrectly asserts that "Dr. Blair concluded that genetics plays a role in approximately 63–75 percent of degenerative disc disease cases." Dr. Blair's findings do not indicate that approximately 75 percent of degenerative disc disease *cases* are caused wholly by genetics, the other approximately 25 percent of *cases* being caused wholly by other factors. Instead, she indicated that degenerative disc disease in adults "'may be explained up to **[*121] [*121]** 75 percent by genes alone.'" In other words, *every* case of degenerative disc disease in adults is caused in part by genetics or heredity, and the other part by other factors. This is also the reason that Rice's claim that [****19] Dr. Blair's opinion lacked evidentiary support is wrong. Rice argues Dr. Blair cannot have known his degenerative disc disease was caused by genetics because she never researched his familial medical history. It was unnecessary for Dr. Blair to conduct such an analysis because her research indicated that genetics or heredity was a majority factor in *all* cases of degenerative disc disease. This explains Dr. Blair's response to Rice's attorney's request that Dr. Blair consider a hypothetical in which one patient has cervical degenerative disease caused by genetics and the other one has the disease caused by environmental factors. She responded that such a hypothetical situation would never be seen in practice and that the assumption was not reasonable.

Dr. Blair's reports meet all of the requirements of *Escobedo*. Dr. Blair expressly stated that confidence in her opinion was predicated on a reasonable degree of medical probability. Dr. Blair gave the reasoning behind her opinion—the published medical studies—and even named the studies and the pages relied upon. Her opinion disclosed familiarity with the concept of apportionment. Labor Code section 4663 states that apportionment is based on causation, and that [****20] "[a] physician shall make an apportionment determination by finding what approximate percentage of [**920] the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors ... ." (Lab. Code, § 4663, subd. (c).)

Dr. Blair's reports reflect an understanding that apportionment is based on the cause of the disability, and the necessity of determining what percentage was caused by Rice's employment. She explained that the causation of his disability stemmed from work activities with the City, prior work activities, prior personal injuries, and personal history. Included in the causes listed as personal history were "heritability and genetics" as supported by medical studies, Rice's brief history of smoking, and his prior diagnosis of lateral epicondylitis.

[***447]

CA(5) **(5)** Dr. Blair's reports reflect, without speculation, that Rice's disability is the result of cervical radiculopathy and cervical degenerative disc disease. Her diagnosis was based on medical history, physical examination, and diagnostic studies that included X-rays and MRI's (magnetic resonance imaging scans). She determined that 49 percent [****21] of his condition was caused by heredity, genomics, and other personal history factors. Her conclusion was based on medical studies that were cited in her report, in addition to an adequate medical history and examination. Dr. Blair's combined reports are more than sufficient to meet the standard of substantial medical evidence.

[*122] [*122]

DISPOSITION

The Workers' Compensation Appeals Board's opinion and decision after reconsideration that was filed January 30, 2015, and that granted reconsideration, is annulled and the matter is remanded to the Board to deny reconsideration. Petitioner is awarded costs.

Hoch ▽, J., and Renner, J. ▽, concurred.

Footnotes

1 "An injury may be either: (a) 'specific,' occurring as the result of one incident or exposure which causes disability or need for medical treatment; or (b) 'cumulative,' occurring as repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment." (Lab. Code, § 3208.1.)

2 Cervical radiculopathy is a "[d]isease or abnormality of a spinal nerve root at its origin in the cervical spine." (1 Schmidt, Attorney's Dict. of Medicine, Illustrated (2010) p. C-175.)

3 The California Applicants' Attorneys Association filed an amicus curiae brief arguing apportionment to genetics is unlawful invidious discrimination pursuant to Government Code section 11135, which prohibits government programs or activities from discrimination on the basis of, inter alia, physical disability or genetic information. We decline to address this argument because it was not raised by petitioner. *HN3* "'Amicus Curiae must accept the issues made and propositions urged by the appealing parties, and any additional questions presented in a brief filed by an amicus curiae will not be considered.' [Citations.] Otherwise, amicus curiae, rather than the parties themselves, would control the issues litigated." (*Lance Camper Manufacturing Corp. v. Republic Indemnity Co.* (2001) 90 Cal.App.4th 1151, 1161, fn. 6 [109 Cal. Rptr. 2d 515].)

Hikida v. Workers' Comp. Appeals Bd., 12 Cal. App. 5th 1249

Copy Citation

Reporter

12 Cal. App. 5th 1249 * 219 Cal. Rptr. 3d 654 ** 82 Cal. Comp. Cases 679 *** 2017 Cal. App. LEXIS 572 ****

MAUREEN HIKIDA, Petitioner, v. WORKERS' COMPENSATION APPEALS BOARD, COSTCO WHOLESALE CORPORATION et al., Respondents.

Subsequent History: Petition for Depublication Denied by Supreme Court September 20, 2017
Time for Granting or Denying Review Extended Hikida v. Workers' Comp. Appeals Bd. & Costco Wholesales Corp., 2017 Cal. LEXIS 6609 (Cal., Aug. 17, 2017)
Review denied by, Request denied by Hikida v. Workers' Comp. Appeals Bd., 2017 Cal. LEXIS 7523 (Cal., Sept. 20, 2017)

Prior History: [****1] W.C.A.B. No. ADJ7721810—WCJ M. Victor Bushin (VNO); W.C.A.B. Panel: Commissioners Zalewski, Lowe, Sweeney (dissenting) [see Hikida v. Costco Wholesale Corp., 2016 Cal. Wrk. Comp. P.D. LEXIS 560 (Appeals Board panel decision)]

Disposition: Proceedings to review a decision of the Workers' Compensation Appeals Board. Writ of review *issued*, WCAB's decision *annulled*, matter remanded with directions, and petitioner to *recover* her costs on appeal.

Core Terms

apportionment, disability, industrial, permanent disability, industrial injury, Appeals, medical treatment, nonindustrial, factors, workers' compensation, threshold issue, reconsideration, tunnel, aggravated, permanent, surgery, carpal, causation, causative, courts, issues, permanent total disability, compensable, appeals board, benefits, provides, syndrome, Cases, psychiatric injury, conclusively

Case Summary

Overview

HOLDINGS: [1]-The appellate court concluded that an employee's petition for review of a decision of the California Workers' Compensation Appeals Board (WCAB) was timely filed; [2]-The appellate court further concluded that despite significant changes in the law governing workers' compensation in 2004, disability resulting from medical treatment for which the employer is responsible is not subject to apportionment; [3]-Nothing in the 2004 legislation had any impact on the reasoning that has long supported the employer's responsibility to compensate for medical treatment and the consequences of medical treatment without apportionment; [4]-Accordingly, the WCJ erred in relying on the 2004 amendment to support apportioning the employee's award, and the WCAB erred in upholding his decision.

Outcome

Order annulled; matter remanded.

▼ LexisNexis® Headnotes

Governments > Legislation > Statute of Limitations > Time Limitations

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review

Workers' Compensation & SSDI > Administrative Proceedings > Claims >

Statute of Limitations

HN1 **Statute of Limitations, Time Limitations**
A petition for writ of review of an order, decision, or award of the California Workers' Compensation Appeals Board (WCAB) must be filed within 45 days after a petition for reconsideration is denied, or, if a petition is granted or reconsideration is had on the appeal board's own motion, within 45 days after the filing of the order, decision, or award following reconsideration. Lab. Code, § 5950. The failure of an aggrieved party to seek judicial review of a final order of the WCAB bars later challenge to the propriety of the order or decision before either the WCAB or the court. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review

HN2 **Administrative Proceedings, Judicial Review**
Generally, an appeal will not lie to review an order made by the California Workers' Compensation Appeals Board where the order remands the matter for a further hearing, leaving issues to be resolved by the workers' compensation judge. Allowing parties to utilize the appellate process on individual issues in a single compensation claim could create a danger of defeating the constitutional objective of administering the workers' compensation laws to accomplish justice in all cases expeditiously, inexpensively, and without incumbrance. At the same time, courts have recognized that permitting early appellate review to resolve certain threshold issues may enhance rather than detract from the expeditious resolution of workers' compensation claims. In general, a threshold issue is one crucial to the employee's right to receive benefits. The fact that an issue is significant or important to the litigation is not sufficient to support a finding that it is a threshold issue. More like this Headnote

Shepardize - Narrow by this Headnote

Governments > Legislation > Interpretation

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review >

Standards of Review

HN3 **Legislation, Interpretation**
The California Workers' Compensation Appeals Board's conclusions on questions of law are reviewed de novo. Its findings on questions of fact are conclusive and final so long as, based on the entire record, they are supported by substantial evidence. When the reviewing court is asked

to interpret and apply a statute to undisputed facts, the review is de novo. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Administrative Proceedings > Awards >

Types of Awards

HN4 **Awards, Types of Awards**
Apportionment is the process employed by the California Workers' Compensation Appeals Board to segregate the residual effects of an industrial injury from those attributable to other industrial injuries, or to nonindustrial factors, in order to fairly allocate the legal responsibility. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Administrative Proceedings > Awards >

Types of Awards

HN5 **Awards, Types of Awards**
New Lab. Code, §§ 4663, subd. (a), & 4664, subd. (a), which were enacted in 2004, eliminate the bar against apportionment based on pathology and asymptomatic causes, while § 4664, subd. (b), was intended to reverse the rule based on Lab. Code, former § 4750, that permitted an injured employee to show rehabilitation of an injury for which a permanent disability award had already been issued. The amendments to the workers' compensation statutes that were made in 2004 were intended to usher in a new regime of apportionment based on causation, and a new approach to apportionment that looks at the current disability and parcels out its causative sources - nonindustrial, prior industrial, current industrial - and decides the amount directly caused by the current industrial source. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits >

Employee Rights

HN6 **Medical Benefits, Employee Rights**
Lab. Code, § 4600, requires the employer to provide medical treatment reasonably required to cure or relieve the injured worker from the effects of his or her injury. Although the wording of this provision has changed over the years, it consistently has been interpreted to require the employer to pay for all medical treatment once it has been established that an industrial injury contributed to an employee's need for it. More like this Headnote

Shepardize - Narrow by this Headnote

Workers' Compensation & SSDI > Administrative Proceedings > Awards

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits >

Employee Rights

HN7 **Administrative Proceedings, Awards**
An employee is entitled to compensation for a new or aggravated injury which results from the medical or surgical treatment of an industrial injury, whether the doctor was furnished by the employer, his or her insurance carrier, or was selected by the employee. More like this Headnote

Shepardize - Narrow by this Headnote

Headnotes/Syllabus

Summary

[*1249] CALIFORNIA OFFICIAL REPORTS SUMMARY

The Workers' Compensation Appeals Board (WCAB) affirmed a decision of a workers' compensation judge (WCJ) to apportion the permanent total disability suffered by an employee between industrial and nonindustrial causes prior to issuing its award.

The Court of Appeal annulled the WCAB's order and remanded the matter. The court concluded that the employee's petition for review was timely filed. The employee's pursuit of her claim to its conclusion, in lieu of seeking review of the WCAB's February 2016 decision, did not represent disregard of a final order. The court further concluded that despite significant changes in the law governing workers' compensation in 2004, disability resulting from medical treatment for which the employer is responsible is not subject to apportionment. Nothing in the 2004 legislation had any impact on the reasoning that has long supported the employer's responsibility to compensate for medical treatment and the consequences of medical treatment without apportionment. Accordingly, the WCJ erred in relying on the 2004 amendment to support apportioning the employee's award, and the WCAB erred in upholding his decision. (Opinion by Manella, J., with Epstein, P. J., and Willhite, J., concurring.)

Headnotes

CALIFORNIA OFFICIAL REPORTS HEADNOTES

CA(1) **(1) Workers' Compensation § 125—Judicial Review—Petition for Reconsideration—Statute of Limitations.**

A petition for writ of review of an order, decision, or award of the Workers' Compensation

Appeals Board (WCAB) must be filed within 45 days after a petition for reconsideration is denied, or, if a petition is granted or reconsideration is had on the appeal board's own motion, within 45 days after the filing of the order, decision, or award following reconsideration (Lab. Code, § 5950). The failure of an aggrieved party to seek judicial review of a final order of the WCAB bars later challenge to the propriety of the order or decision before either the WCAB or the court.

CA(2) **(2) Workers' Compensation § 125—Judicial Review—Threshold Issues—Right to Receive Benefits.**

Generally, an appeal will not lie to review an order made by the Workers' Compensation Appeals Board where the order remands the matter for a further hearing, leaving issues to be resolved by the workers' compensation judge. Allowing parties to utilize the appellate process on individual issues in a single compensation claim could create a danger of defeating the constitutional objective of administering the workers' compensation laws to accomplish justice in all cases expeditiously, inexpensively, and without incumbrance. At the same time, courts have recognized that permitting early appellate review to resolve certain threshold issues may enhance rather than detract from the expeditious resolution of workers' compensation claims. In general, a threshold issue is one crucial to the employee's right to receive benefits. The fact that an issue is significant or important to the litigation is not sufficient to support a finding that it is a threshold issue.

CA(3) **(3) Workers' Compensation § 82—Award—Apportionment—Industrial Injury—Legal Responsibility.**

Apportionment is the process employed by the Workers' Compensation Appeals Board to segregate the residual effects of an industrial injury from those attributable to other industrial injuries, or to nonindustrial factors, in order to fairly allocate the legal responsibility.

CA(4) **(4) Workers' Compensation § 82—Award—Apportionment—Causation.**

New Lab. Code, §§ 4663, subd. (a), and 4664, subd. (a), which were enacted in 2004, eliminate the bar against apportionment based on pathology and asymptomatic causes, while § 4664, subd. (b), was intended to reverse the rule based on Lab. Code, former § 4750, that permitted an injured employee to show rehabilitation of an injury for which a permanent disability award had already been issued. The amendments to the workers' compensation statutes that were made in **[*1251]** 2004 were intended to usher in a new regime of apportionment based on causation, and a new approach to apportionment that looks at the current disability and parcels out its causative sources—nonIndustrial, prior industrial, current industrial—and decides the amount directly caused by the current industrial source.

CA(5) **(5) Workers' Compensation § 115—Medical Treatment—Industrial Injury.**

Lab. Code, § 4600, requires the employer to provide medical treatment reasonably required to

cure or relieve the injured worker from the effects of his or her injury. Although the wording of this provision has changed over the years, it consistently has been interpreted to require the employer to pay for all medical treatment once it has been established that an industrial injury contributed to an employee's need for it.

CA(6) **(6) Workers' Compensation § 82—Award—New or Aggravated Injury—Industrial Injury.**

An employee is entitled to compensation for a new or aggravated injury which results from the medical or surgical treatment of an industrial injury, whether the doctor was furnished by the employer, his or her insurance carrier, or was selected by the employee.

CA(7) **(7) Workers' Compensation § 83—Award—Apportionment—Medical Treatment—Changes in Law.**

Despite significant changes in the law governing workers' compensation in 2004, disability resulting from medical treatment for which the employer is responsible is not subject to apportionment. Nothing in the 2004 legislation had any impact on the reasoning that has long supported the employer's responsibility to compensate for medical treatment and the consequences of medical treatment without apportionment. Accordingly, the workers' compensation judge erred in relying on the 2004 amendment to support apportioning an employee's award, and the Workers' Compensation Appeals Board erred in upholding his decision.

[Herlick, California Workers' Compensation Law (6th ed. 2016) ch. 4, § 4.01.]

▼ California Compensation Headnotes/Summary

Headnotes

Petitions for Writ of Review > Time to File > Final Awards

Court of Appeal, annulling decision of WCAB and remanding matter, held that applicant's petition for writ of review was timely filed, when Court of Appeal [*680] found that WCAB opinion of February 8, 2016, was not, contrary to defendant's assertion, "final decision" with respect to apportionment issue since it remanded matter for further hearing on that issue, that WACB opinion of February 8, 2016, did not decide threshold issue crucial to applicant's right to receive benefits, and that there was no reason why applicant should have been compelled to seek immediate writ review of issue that may not have been dispositive of his award.**

[See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 34.10[2], [3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 20, §§ 20.01[2], 20.07[6].]

Medical Treatment > Permanent Disability Arising from Medical Treatment > Apportionment

Court of Appeal, annulling decision of WCAB and remanding matter, held that disability resulting from medical treatment for which defendant was responsible was not subject to apportionment, when Court of Appeal found that applicant, while employed by defendant, developed carpel tunnel syndrome, that, following surgery, applicant developed chronic regional pain syndrome, which caused debilitating pain in her upper extremities and severely impaired her ability to function, that agreed medical evaluator found applicant to be permanently totally disabled from labor market, due entirely to effects of chronic regional pain syndrome that she developed as result of failed carpal tunnel surgery, that agreed medical evaluator also concluded that applicant's carpal tunnel condition itself was 90 percent due to industrial factors and 10 percent to nonindustrial factors, that none of changes in apportionment law since 2004 had changed rule that it is error to apportion permanent disability resulting from medical treatment based on cause of injury that was being treated, and that applicant was, therefore, entitled to finding of permanent total disability.

[See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[6], 8.06[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, § 7.42[1], 3].]

Counsel: Law Firm of Rowen, Gurvey & Win and Alan Z. Gurvey for Petitioner.

Law Office of Mark Gearhert and Justin C. Sonnicksen for California Applicants' Attorneys Association as Amicus Curiae on behalf of Petitioner. **[*1252]**

Mullen & Filippi, Jay S. Cohen, Daniel Nachison; Seyfarth & Shaw and Kiran A. Seldon for Respondents Costco Wholesale Corporation and Helmsman Management Services.

John F. Shields and Peter Ray for Respondent Workers' Compensation Appeals Board.

Judges: Opinion by Manella, J., with Epstein, P. J., and Willhite, J., concurring.

Opinion by: Manella, J.

Opinion

[**656] **MANELLA, J.**—Petitioner Maureen Hikida seeks review of an order of respondent Workers' Compensation Appeals Board (the Board) affirming the decision of the workers' compensation judge (WCJ) to apportion the permanent total disability suffered by petitioner between industrial and nonindustrial causes prior to issuing its award. Petitioner contends that because the agreed medical examiner (AME) concluded her permanent total disability was the result of a failed surgery for carpal

tunnel syndrome, a condition she contracted primarily [****2] due to the clerical work she performed for respondent Costco Wholesale Corporation (Costco) for more than 25 years, apportionment was not appropriate.[1] After briefing on the merits was complete, respondents filed a supplemental brief raising [***681] a "question" as to this court's jurisdiction. Specifically, respondents suggested the writ petition might have been untimely, because the issue of apportionment was resolved by the Board months before the Board denied reconsideration of the WCJ's final award. We conclude the petition was timely filed. We further conclude that despite significant changes in the law governing workers' compensation in 2004, disability resulting from medical treatment for which the employer is responsible is not subject to apportionment. Accordingly, we annul the Board's order and remand for an increase in petitioner's disability award.

FACTUAL AND PROCEDURAL BACKGROUND

Petitioner was employed by respondent Costco from November 1984 to May 2010. During this period, she developed a number of medical conditions, including carpel tunnel syndrome.[2] In May 2010, she took leave from **[*1253]** work to undergo carpel tunnel surgery.[3] Following [**657] the surgery, she developed chronic regional [****3] pain syndrome (CRPS), a condition that caused her debilitating pain in her upper extremities and severely impaired her ability to function. She never returned to work. The parties stipulated she became permanent and stationary on May 2, 2013.

In 2012 and 2013, petitioner was examined by an AME in orthopedics, Chester Hasday, M.D. Dr. Hasday found petitioner permanently and totally disabled from the labor market. He found that her permanent total disability was due entirely to the effects of the CRPS that she developed as a result of the failed carpal tunnel surgery. He further concluded that petitioner's carpal tunnel condition itself was 90 percent due to industrial factors and 10 percent to nonindustrial factors.[4]

In issuing the award, the WCJ found that petitioner's permanent total disability was 90 percent due to industrial factors, "after adjustment for apportionment." Petitioner sought reconsideration by the Board, contending her disability was 100 percent industrial because it derived from medical treatment, entitling her to an unapportioned award. The WCJ prepared a report and recommendation, in which he recommended denying the petition for reconsideration, stating that he was [****4] "obligated under Labor Code section 4663 to address apportionment of permanent disability to factors other than applicant's industrial injury."

[***682]

On February 8, 2016, in a two-to-one decision, the Board affirmed the apportionment. The majority concluded: "To properly evaluate the issue of apportionment of permanent disability, it is necessary to 'parcel out' the causative sources of the permanent disability, nonindustrial, prior industrial and current industrial, and 'decide the amount directly caused by the current industrial source.' [Citation.] [¶] As the WCJ notes in the Report, the AME Dr. Hasday concluded that [petitioner's] CRPS caused her to be totally permanently disabled. However, there is a basis for apportionment of that permanent disability to nonindustrial causative sources as found by the WCJ because the CRPS was caused by the surgery to treat [petitioner's] carpal tunnel condition, which is 10 percent nonindustrial and 90 percent industrial as opined by Dr. Hasday. [Citation.]" (Quoting *Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1328 [57 Cal.Rptr.3d 644, 156 P.3d 1100] (*Brodie*).) The Board nonetheless granted the petition for reconsideration, finding the WCJ had failed to take into account medical reports showing **[*1254]** petitioner suffered employment-related psychiatric injuries [****5] that "need[] to be taken into account along with the other industrial causative sources in determining the level of compensable permanent disability resulting from the industrial injury."

The dissent, citing multiple cases holding that an employee is entitled to compensation for new or aggravated injury resulting from the medical or surgical treatment of an industrial injury, stated the WCJ erred "because he apportioned the permanent disability caused by [petitioner's] CRPS based upon the causation of [her] underlying carpal tunnel injury and not upon the cause of her permanent

disability ... . In that the CRPS causing [petitioner's] total permanent disability resulted entirely from the surgery reasonably performed to treat [her] industrial carpal tunnel injury, it is error to apportion the permanent disability resulting from that medical treatment based upon the causes [**658] of the injury that was being treated." (Italics omitted.)

After the Board issued its February 2016 decision remanding the case, petitioner prepared a trial brief urging the WCJ to find her 100 percent disabled based on the psychiatric injury, which she alleged was entirely industrial. Petitioner further contended that [****6] the vocational expert's opinion supported a 100 percent award, and that a 100 percent award was required under section 4662, subdivision (b) due to her inability to fully use her arms and hands.[5] The WCJ increased petitioner's disability award to 98 percent after apportionment. Following issuance of the amended award, petitioner filed a second petition for reconsideration seeking increase in the award on a number of grounds, including the vocational expert's opinion and section 4662. She also asked the Board to revisit the appropriateness of apportionment. By order dated October 25, 2016, the Board again denied reconsideration, finding apportionment appropriate in a two-to-one [***683] decision for the reasons previously stated. The writ petition seeking review of the Board's decision was filed December 9, 2016.[6]

[*1255]

DISCUSSION

A. *Timeliness of Appeal*

Shortly before oral argument, respondents Costco and Helmsman filed a supplemental brief contending the Board's February 8, 2016 opinion was "likely" the "final decision" with respect to the apportionment issue, and that the appeal should be dismissed as untimely. For the reasons set forth below, we disagree.

CA(1) **(1)** Section 5950 provides that "[a]ny person affected by an order, decision, or award of the [Board] may [****7] ... apply to the Supreme Court or to the court of appeal for the appellate district in which he resides, for a writ of review ... ." ***HN1*** The petition for writ of review must be filed "within 45 days after a petition for reconsideration is denied, or, if a petition is granted or reconsideration is had on the appeal board's own motion, within 45 days after the filing of the order, decision, or award following reconsideration." (§ 5950.) "The failure of an aggrieved party to seek judicial review of a final order of the [Board] bars later challenge to the propriety of the order or decision before either the [Board] or the court." (*State Farm General Ins. Co. v. Workers' Comp. Appeals Bd.* (2013) 218 Cal.App.4th 258, 261 [159 Cal. Rptr. 3d 779].)

HN2 ***CA(2)*** **(2)** Generally, an appeal will not lie to review an order made by the Board where the order remands the matter for a further hearing, leaving issues to be resolved by the WCJ. (*Gumilla v. Industrial Acc. Com.* (1921) 187 Cal. 638, 639–640 [203 P. 397]; *Safeway Stores, Inc. v. Workers' Comp. Appeals Bd.* (1980) 104 Cal.App.3d 528, 533 [163 Cal. Rptr. 750] (*Safeway Stores*).) "Allowing parties to utilize the appellate process on individual issues in a single compensation claim could create a danger of defeating [the California] constitutional objective" of administering the [**659] workers' compensation laws to "accomplish justice in all cases 'expeditiously, inexpensively, and without incumbrance ... .'" (*Safeway Stores, supra*, at p. 533, italics omitted; see *Maranian v. Workers' Comp. Appeals Bd.* (2000) 81 Cal.App.4th 1068, 1073 [97 Cal. Rptr. 2d 418] (*Maranian*) ["The well-known [****8] final judgment rule that governs general civil appeals was designed to prevent costly piecemeal dispositions and multiple reviews which burden the courts and impede the judicial process"].) At the same time, courts have recognized that permitting early appellate review to resolve certain "threshold issues" may enhance rather than detract from the expeditious resolution of workers' compensation claims. (*Safeway Stores, supra*, at p. 533; see *Maranian, supra*, at p. 1078.)

[***684]

In general, a threshold issue is one "crucial to the employee's right to receive benefits." (*Maranian, supra*, 81 Cal.App.4th at p. 1078; see 2 Hanna, **[*1256]** Cal. Law of Employee Injuries and Workers' Compensation (2d rev. ed. 2011) § 28.04, p. 28-11 ["A threshold issue is an issue that is basic to the establishment of the employee's right to benefits, such as the territorial jurisdiction of the Board, the existence of the employment relationship, and statute of limitations issues" (fn. omitted)].) The fact that an issue is significant or important to the litigation is not sufficient to support a finding that it is a threshold issue. As the court stated in *Ogden Entertainment Services v. Workers' Comp. Appeals Bd.* (2014) 233 Cal.App.4th 970, 986, 987 [183 Cal. Rptr. 3d 205] although the determination "[w]hether the [worker's] psychiatric injury was industrial" was "one of the principal issues" before the Board, "[t]he disposition by the appeals board of one of several [****9] issues on the merits is not a final decision of the appeals board"; "[i]t is only a final order, decision, or award of the appeals board that is reviewable by this court by way of a petition for a writ of review."[7]

The Board's February 2016 decision was not a final order disposing of the case, as it remanded the matter to the WCJ to determine the amount of compensation to be awarded for the psychiatric disability and other issues raised by petitioner. Nor was the Board's decision on apportionment a threshold issue, "crucial to [petitioner's] right to receive benefits." (*Maranian, supra*, 81 Cal.App.4th at p. 1078.) Petitioner was entitled to benefits regardless of apportionment, and respondents essentially conceded petitioner's disability was at least 90 percent the result of industrial factors. On remand to [**660] the WCJ, petitioner advanced multiple theories to warrant a 100 percent award without regard to apportionment. By maximizing her award in the workers' compensation proceedings before resorting to the courts, petitioner was following a path that could have led to an expeditious resolution of the proceeding without the need for appellate review. We discern no reason an applicant should be compelled to [****10] seek immediate writ review of an issue that may not be dispositive of his or her award. In short, we conclude petitioner's pursuit of her claim to its conclusion, in lieu of seeking review of the Board's **[*1257]** February 2016 [***685] decision, did not represent disregard of a final order. Accordingly, we deny respondent's request for dismissal.[8]

B. *Merits*

We turn now to the merits of petitioner's assertion that the Board erred when it found that despite the AME's unchallenged opinion that petitioner's CRPS resulting from the failed surgery rendered her totally disabled, the Board deemed her permanent total disability to be 90 percent due to industrial factors after apportionment.

HN3 The Board's conclusions on questions of law are reviewed de novo. (*Benson v. Workers' Comp. Appeals Bd.* (2009) 170 Cal.App.4th 1535, 1543 [89 Cal. Rptr. 3d 166].) Its findings on questions of fact "are conclusive and final so long as, based on the entire record, they are supported by substantial evidence." (*Save Mart Stores v. Workers' Comp. Appeals Bd.* (1992) 3 Cal.App.4th 720, 723 [4 Cal. Rptr. 2d 597].) When the reviewing court is asked to interpret and apply a statute to undisputed facts, the review is de novo. (*Benson, supra*, at p. 1543.)

1. *Changes in the Law of Apportionment*

HN4 ***CA(3)*** **(3)** "'Apportionment is the process employed by the Board to segregate the residual[] [effects] of an industrial injury from those attributable to other industrial injuries, [****11] or to nonindustrial factors, in order to fairly allocate the legal responsibility.'" (*Brodie, supra*, 40 Cal.4th at p. 1321.) Prior to 2004, apportionment was "closely circumscribed." (*Id.* at p. 1326.) Former section 4663, governing apportionment where an industrial injury aggravated a preexisting nonindustrial condition leading to disability, was interpreted as permitting apportionment "'only if the [B]oard f[ound] that part of the disability would have resulted from the normal progress of the underlying **[*1258]** nonindustrial disease.'"[9] (*Brodie, supra*, at p. 1326; [**661]

see [***686] *Gay v. Workers' Comp. Appeals Bd.* (1979) 96 Cal.App.3d 555, 562 [158 Cal. Rptr. 137] ["[T]o support apportionment of nonindustrial disability under [former] section 4663, there must be medical evidence expressly stating that the apportioned disability is the result of the natural progression of the preexisting nonindustrial condition and such nonindustrial disability would have occurred even in absence of the industrial injury"].) This rule was said to flow from the principle that an employer "takes the employee as he finds him at the time of the employment" (*Ballard v. Workmen's Comp. App. Bd.* (1971) 3 Cal.3d 832, 837 [92 Cal.Rptr. 1, 478 P.2d 937]), and that an employee could not be denied compensation "merely because his physical condition was such that he sustained a disability which a person of stronger constitution or in better health would not have suffered." (*Duthie v. Workers' Comp. Appeals Bd.* (1978) 86 Cal.App.3d 721, 727 [150 Cal. Rptr. 530].) The rule "left employers liable for any portion [****12] of a disability that would not have occurred but for the current industrial cause; if the disability arose in part from an interaction between an industrial cause and a nonindustrial cause, but the nonindustrial cause would not alone have given rise to a disability, no apportionment was to be allowed." (*Brodie, supra*, at p. 1326.) "[S]o long as the industrial cause was a but-for proximate cause of the disability, the employer w[as] liable for the entire disability, without apportionment." (*Ibid.*; see, e.g., *Franklin v. Workers' Comp. Appeals Bd.* (1978) 79 Cal.App.3d 224, 247 [145 Cal. Rptr. 22] [where employee with history of high cholesterol and arteriosclerosis suffered heart attack while working, no apportionment was required for disability attributable to heart attack "because industrial factors aggravated the heart disease and accelerated the occurrence of the infarct, which absent the industrial exposure would not have occurred when it did"].)

In addition, prior to 2004, former section 4750—which governed apportionment between a current and past industrial injury—was interpreted as allowing the employee to defeat apportionment by establishing rehabilitation of an injury for which a permanent disability award had already been issued.[10] (See, e.g., *Robinson v. Workers' Comp. Appeals Bd.* (1981) 114 Cal.App.3d 593, 602 [171 Cal. Rptr. 48] ["[T]he fact that a worker received a **[*1259]** permanent disability rating [****13] for his earlier injury, and was in fact partially disabled for some period of time, does not provide a basis for apportionment. ... '[I]f an injured employee recovers and thereafter is again injured, he is entitled to compensation for the injury to his rehabilitated condition, not limited in amount by the terms of [***687] a former award'"]; *National Auto. & Cas. Ins. Co. v. Industrial Acc. Com.* (1963) 216 Cal.App.2d 204, 211 [30 Cal.Rptr. 685] [worker who had been found 65 percent disabled after suffering first back [**662] injury and 78 percent after suffering second back injury entitled to 39 percent award where evidence established "a substantial improvement of his bodily condition in the period of time which elapsed prior to the second injury"]; see *id.*, at pp. 206–211.)

CA(4) **(4)** As the Supreme Court explained in *Brodie*, reversing these constraints on apportionment was a key goal of the Legislature when it amended the governing statutes in 2004, eliminating former section 4750, rewriting section 4663 and adding section 4664:[11] "The plain language of new sections 4663 and 4664 demonstrates they were intended to reverse these features of former section 4663 and 4750. [Citation.] ... ***HN5*** [N]ew sections 4663, subdivision (a) and 4664, subdivision (a) eliminate the bar against apportionment based on pathology and asymptomatic causes [citations], while section 4664, subdivision (b) was intended to reverse the rule based on former section 4750 that permitted an injured employee to show rehabilitation of [****14] an injury for which a permanent disability award had already been issued [citations]." (*Brodie, supra*, 40 Cal.4th at pp. 1327, 1328.) In other words, the amendments were intended to usher in a "new regime of apportionment based on causation," and a "new approach to apportionment" that "look[s] at the current disability and parcel[s] out its causative sources—nonindustrial, prior **[*1260]** industrial, current industrial—and decide[s] the amount directly caused by the current industrial source." (*Id.* at pp. 1327–1328.)[12]

[***688]

2. *Disability Caused by Medical Treatment of an Industrial Injury*

Under the changes wrought by the 2004 amendments, the disability arising from petitioner's carpal tunnel syndrome was apportionable between industrial and nonindustrial causes. However, petitioner's permanent total disability was caused not by her carpal tunnel condition, but by the

[**663] CRPS resulting from the medical treatment her employer provided. The issue presented is whether an employer is responsible for both the medical treatment and any disability arising directly from unsuccessful medical intervention, without apportionment. For the reasons discussed below, we conclude it is.[13]

[*1261]

HN6 ***CA(5)*** **(5)** Section 4600 requires the employer to provide medical treatment "reasonably required to cure or relieve the injured worker from the effects of his or her injury ... ." (See also § 4601 [stating that treatment by consulting physician and certain other medical providers requested by the employee "shall be at the expense of the employer"].) Although the wording of this provision has changed over the years, it consistently has been interpreted to require the employer to pay for all [***689] medical treatment "[o]nce it has been established that an industrial injury contributed to an employee's need for [it] ... ." (*Rouseyrol v. Workers' Comp. Appeals Bd.* (1991) 234 Cal.App.3d 1476, 1485 [286 Cal. Rptr. 250]; accord, *Granado v. Workmen's Comp. App. Bd.* (1968) 69 Cal.2d 399, 405–406 [71 Cal.Rptr. 678, 445 P.2d 294] (*Granado*); *Sanchez v. Brooke* (2012) 204 Cal.App.4th 126, 140–141 [138 Cal. Rptr. 3d 507]; *Boehm & Associates v. Workers' Comp. Appeals Bd.* (2003) 108 Cal.App.4th 137, 142 [133 Cal. Rptr. 2d 396]; *Buhlert Trucking v. Workers' Comp. Appeals Bd.* (1988) 199 Cal.App.3d 1530, 1532 [247 Cal. Rptr. 190]; *Deauville v. Hall* (1961) 188 Cal.App.2d 535, 540–541 [10 Cal. Rptr. 511].)

In *Granado*, the Supreme Court provided the following rationale for its conclusion that "medical expense is not apportionable": [**664] "If medical expense reasonably necessary to relieve from the industrial injury were apportionable, a workingman, who is disabled, may not be able to pay his share of the expense and thus forego treatment. Moreover, the uncertainties attendant to the determination of the proper apportionment might cause employers to refuse to pay their share until there has been a hearing and decision on the question of apportionment, and such delay [****16] in payment may compel the injured workingman to forego the prompt treatment to which he is entitled." (*Granado, supra*, 69 Cal.2d at pp. 405–406.)

CA(6) **(6)** It also has long been the rule that "the aggravation of an industrial injury or the infliction of a new injury resulting from its treatment or examination are compensable under the provisions of the Workmen's Compensation Act and, therefore, within the exclusive cognizance of the Industrial Accident Commission."[14] (*Fitzpatrick v. Fidelity & Casualty Co.* (1936) 7 Cal.2d 230, 232 [60 P.2d 276]; accord, *Nelson v. Associated Indem. Corp.* (1937) 19 Cal.App.2d 564, 566 [66 P.2d 184].) Aggravation of the original industrial injury by medical treatment is considered "a foreseeable consequence of the original compensable injury, compensable within the workers' compensation proceeding and not the proper subject of an independent common law damage proceeding against the employer." (*Nation v. Certainteed* **[*1262]** Corp. (1978) 84 Cal.App.3d 813, 817 [149 Cal. Rptr. 62], italics omitted.) Accordingly, ***HN7*** "an employee is entitled to compensation for a new or aggravated injury which results from the medical or surgical treatment of an industrial injury, whether the doctor was furnished by the employer, his insurance carrier, or was selected by the employee." (*Fitzpatrick v. Fidelity & Casualty Co., supra*, at pp. 233–234.)

In *Deauville v. Hall, supra*, 188 Cal.App.2d 535, the court explained that depriving the employee of compensation for aggravation of an industrial injury resulting from negligent medical treatment could lead to "an action in a court of law [****17] against an employer for the latter's negligence in providing that medical [***690] treatment." (*Id.* at pp. 540–541.) Such "independent suits" would "ultimately result in a breakdown in the system of compensation for industrial injuries and create unwarranted confusion and increased unnecessary litigation ... ." (*Id.* at p. 541; see also *Noe v. Travelers Ins. Co.* (1959) 172 Cal.App.2d 731, 737 [342 P.2d 976] ["[I]f delay in medical service attributable to a carrier could give rise to independent third party court actions, the system of workmen's compensation could be subjected to a process of partial disintegration. In the practical operation of the plan, minor delays in getting medical service, such as for a few days or even a few hours, caused by a carrier, could become the bases of independent suits, and these could be many and manifold indeed. The uniform and exclusive application of the law would become honeycombed with independent and conflicting rulings of the courts. The objective of the Legislature and the whole pattern of workmen's compensation could thereby be partially nullified"].)

Here, there is no dispute that the disabling carpal tunnel syndrome from which petitioner suffered

was largely the result of her many years of clerical employment with Costco. It followed that Costco was [****18] required to provide medical treatment to [**665] resolve the problem, without apportionment. The surgery went badly, leaving appellant with a far more disabling condition—CRPS—that will never be alleviated. California workers' compensation law relieves Costco of liability for any negligence in the provision of the medical treatment that led to petitioner's CRPS. It does not relieve Costco of the obligation to compensate petitioner for this disability without apportionment.

CA(7) **(7)** Our review of the authorities convinces us that in enacting the "new regime of apportionment based on causation," the Legislature did not intend to transform the law requiring employers to pay for all medical treatment caused by an industrial injury, including the foreseeable consequences of such medical treatment. Pre-2004 law constraining the application of apportionment in the award of permanent disability benefits was based primarily on the interpretation of former sections 4663 and 4750, which were eliminated or fundamentally altered by the 2004 amendments. The long-standing rule that **[*1263]** employers are responsible for all medical treatment necessitated in any part by an industrial injury, including new injuries resulting from that medical [****19] treatment, derived not from those statutes, but from (1) the concern that applying apportionment principles to medical care would delay and potentially prevent an injured employee from getting medical care, and (2) the fundamental proposition that workers' compensation should cover all claims between the employee and employer arising from work-related injuries, leaving no potential for an independent suit for negligence against the employer. Nothing in the 2004 legislation had any impact on the reasoning that has long supported the employer's responsibility to compensate for medical treatment and the consequences of medical treatment without apportionment. Accordingly, the WCJ erred in relying on the 2004 amendment to support apportioning petitioner's award, and the Board erred in upholding his decision.

[***691]

DISPOSITION

The order of the Board on reconsideration is annulled. The matter is remanded to the Board for further proceedings consistent with the view expressed in this opinion. Petitioner shall recover her costs.

Epstein, P. J., and Willhite, J., concurred.

Footnotes

[1] Costco is adjusted by respondent Helmsman Management Services (Helmsman). We granted permission to California Applicants' Attorneys Association to file an amicus curiae brief in support of petitioner.

2 Pursuant to stipulation of the parties, the WCJ found that petitioner "sustained injury arising out of and in the course of employment to her cervical spine, thoracic spine, upper extremities, ... psyche, fingers, [and] elbows ... ." He further found that she suffered from employment-related headaches, memory loss, sleep disorder, and "deconditioning." Petitioner claimed to have other medical conditions, including hypertension and irritable bowel syndrome, but the WCJ did not find them employment related.

3 Medical reports indicate petitioner was considered temporarily totally disabled at this time. Medical treatment was provided under the auspices of workers' compensation law. (See Lab. Code, § 4600.) (Undesignated statutory references are to the Labor Code.)

4 Petitioner was also evaluated by a vocational expert who found her permanently and totally disabled, without access to any occupation in the open labor market.

5 Section 4662, subdivision (a) provides: "Any of the following permanent disabilities shall be conclusively presumed to be total in character: [¶] ... [¶] (2) Loss of both hands or the use thereof."

6 Respondents Costco and Helmsman filed an answer. The Board submitted a letter to the court stating it would not answer the petition because "the decisions of the [WCJ] and the *Appeals Board provide the reasons and record for the [Board's] decision in this case* ... ." The letter stated: "When the Appeals Board denied reconsideration of the WCJ's August 3, 2016 Decision on October 25, 2016, the August 3, 2016 Decision of the WCJ became the final decision of the [Board] in this case for purposes of appellate review."

7 In *Safeway Stores*, the court agreed to decide whether the worker's injury arose out of and in the course of employment. (*Safeway Stores, supra*, 104 Cal.App.3d at p. 533.) Since then, courts have defined "threshold issue[]" to include whether California workers' compensation law applied to a professional athlete who played a single game in California (*Federal Ins. Co. v. Workers' Comp. Appeals Bd. (Johnson)* (2013) 221 Cal.App.4th 1116, 1119–1122 [165 Cal. Rptr. 3d 288]); whether an employer failed to reject the worker's claim within the requisite statutory period (*Maranian, supra*, 81 Cal.App.4th at pp. 1080–1081); and whether a worker of less than six months was barred from recovering compensation benefits for a claimed psychological injury (*Wal-Mart Stores, Inc. v. Workers' Comp. Appeals*

Bd. (2003) 112 Cal.App.4th 1435, 1438, fn. 3 [5 Cal. Rptr. 3d 822] (*Wal-Mart Stores*)). Courts have found that the determination whether a psychiatric injury is industrial is not a threshold issue (*Ogden Entertainment Services v. Workers' Comp. Appeals Bd., supra*, 233 Cal.App.4th at pp. 986–987), and that an order denying a petition to strike a physician's report and remove her as an AME is not a threshold issue (*Capital Builders Hardware, Inc. v. Workers' Comp. Appeals Bd.* (*Gaona*) (2016) 5 Cal.App.5th 658, 662 [210 Cal. Rptr. 3d 101]).

8

We observe that in the authorities relied on by respondents, the courts saved an otherwise premature appeal by deeming the issue involved a "threshold issue." (*Safeway Stores, supra*, 104 Cal.App.3d at pp. 531, 535; *Maranian, supra*, 81 Cal.App.4th at p. 1070; *Wal-Mart Stores, supra*, 112 Cal.App.4th at p. 1438, fn. 3; *Kosowski v. Workers' Comp. Appeals Bd.* (1985) 170 Cal.App.3d 632, 636 [216 Cal. Rptr. 280]; *Duncan v. Workers' Comp. Appeals Bd.* (2008) 166 Cal.App.4th 294, 299 [82 Cal. Rptr. 3d 664]; see also *Matea v. Workers' Comp. Appeals Bd.* (2006) 144 Cal.App.4th 1435, 1442, fn. 3 [51 Cal. Rptr. 3d 314]; *Kopping v. Workers' Comp. Appeals Bd.* (2006) 142 Cal.App.4th 1099, 1105, fn. 6 [48 Cal. Rptr. 3d 618].) Respondents have not cited—and we have not found—a case in which an appellate court has dismissed an applicant's petition for review because an earlier Board order remanding a case for further proceedings was determined to have resolved a threshold issue. Courts should be cautious in finding a "threshold issue" where such finding will deprive a party of the right to an appeal.

9

Former section 4663 provided: "In case of aggravation of any disease existing prior to a compensable injury, compensation shall be allowed only for the proportion of the disability due to the aggravation of such prior disease which is reasonably attributed to the injury." (Stats. 1937, ch. 90, § 4663, p. 284.)

10

Former section 4750 provided: "An employee who is suffering from a previous permanent disability or physical impairment and sustains permanent injury thereafter shall not receive from the employer compensation for the later injury in excess of the compensation allowed for such injury when considered by itself and not in conjunction with or in relation to the previous disability or impairment. [¶] The employer shall not be liable for compensation to such an employee for the combined disability, but only for that portion due to the later injury as though no prior disability or impairment had existed." (Stats. 1945, ch. 1161, § 1, p. 2209.)

11

Section 4663 currently provides that "[a]pportionment of permanent disability shall be

based on causation" and "[a] physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall address in that report the issue of causation of the permanent disability" which "must include an apportionment determination" stating "what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries."

Section 4664 provides: "(a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment. [¶] (b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof. [¶] (c)(1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. ..."

12

The Board had come to a similar conclusion in *Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, in which it stated: "[I]n [enacting the 2004 changes], ... the Legislature intended to expand ... the scope of legally permissible apportionment. ... [S]ection 4663(c) provides for apportionment based on 'what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries.' ... [T]his language appears to reflect a legislative intent to enlarge the range of factors that may be considered in determining the cause of permanent disability... ." (*Id.* at pp. 616–617, italics omitted.)

13

Petitioner and amicus curiae contend this issue has been resolved, citing *County of Sacramento v. WCAB (Chimeri)* (2010) 75 Cal.Comp.Cases 159, *Nilsen v. Vista Ford* (Oct. 26, 2012, W.C.A.B. No. ADJ630145) 2012 Cal.Wrk.Comp. P.D. Lexis 528, *Moran v. Dept. of Youth Authority* (Jan. 21, 2011, W.C.A.B. Nos. ADJ2192153, ADJ710643) 2011 Cal.Wrk.Comp. P.D. Lexis 43, and *Steinkamp v. City of Concord* (Mar. 30, 2006, W.C.A.B. Nos. OAK 316754, WCK 0028639, WCK 0031066, WCK 0050335) 2006 Cal.Wrk.Comp. P.D. Lexis 24. In *Chimeri*, the employee became disabled after breaking his foot at work, which led him to suffer CRPS and become addicted to pain medication. The permanent total disability there was 100 percent work related. In *Nilsen*, the employee similarly suffered a serious injury at work leading to CRPS and dependency on pain medication. The defendant sought to attribute some of the disability to the employee's preexisting back condition, but the Board found no evidence that his preexisting back condition had contributed to his disability. In *Moran*, the employee suffered two injuries at work, and the issue was whether apportionment between the prior injury and the current injury was warranted. The Board found the defendant had failed to meet its burden of proving the prior injury overlapped the current one. Of the cited cases,

only *Steinkamp* addressed the issue squarely. There, the employee's cumulative knee injury was the result of various factors, some industrial and some not. He underwent knee surgery, which led to permanent disability. The Board concluded apportionment was not warranted because "medical treatment is not apportionable." However, *Steinkamp* was not designated a significant panel decision and its precedential value is limited.

Petitioner further contends this matter was resolved in *Escobedo* [****15] v. Marshalls, in which the Board stated: "Section 4663(a)'s statement that the apportionment of permanent disability shall be based on 'causation' refers to the causation of the permanent disability, not causation of the injury, and the analysis of the causal factors of permanent disability for purposes of apportionment may be different from the analysis of the causal factors of the injury itself." (*Escobedo v. Marshalls, supra*, 70 Cal.Comp.Cases at p. 607.) In *Escobedo*, the employee's disability was not the result of medical treatment. The Board addressed apportionment where the disability was caused 50 percent by an industrial injury and 50 percent by a preexisting degenerative condition. "'[A]n opinion is not authority for a proposition not therein considered.'" (*Westly v. Board of Administration* (2003) 105 Cal.App.4th 1095, 1112 [130 Cal. Rptr. 2d 149].)

14 The Industrial Accident Commission was replaced by the Board in 1966. (*Ramirez v. Workers' Comp. Appeals Bd.* (2017) 10 Cal.App.5th 205, 220, fn. 7 [215 Cal. Rptr. 3d 723].)

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Orthopedic Medicine and the Med/Legal Process

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UNDERSTANDING SHOULDER INJURY AND TREATMENT

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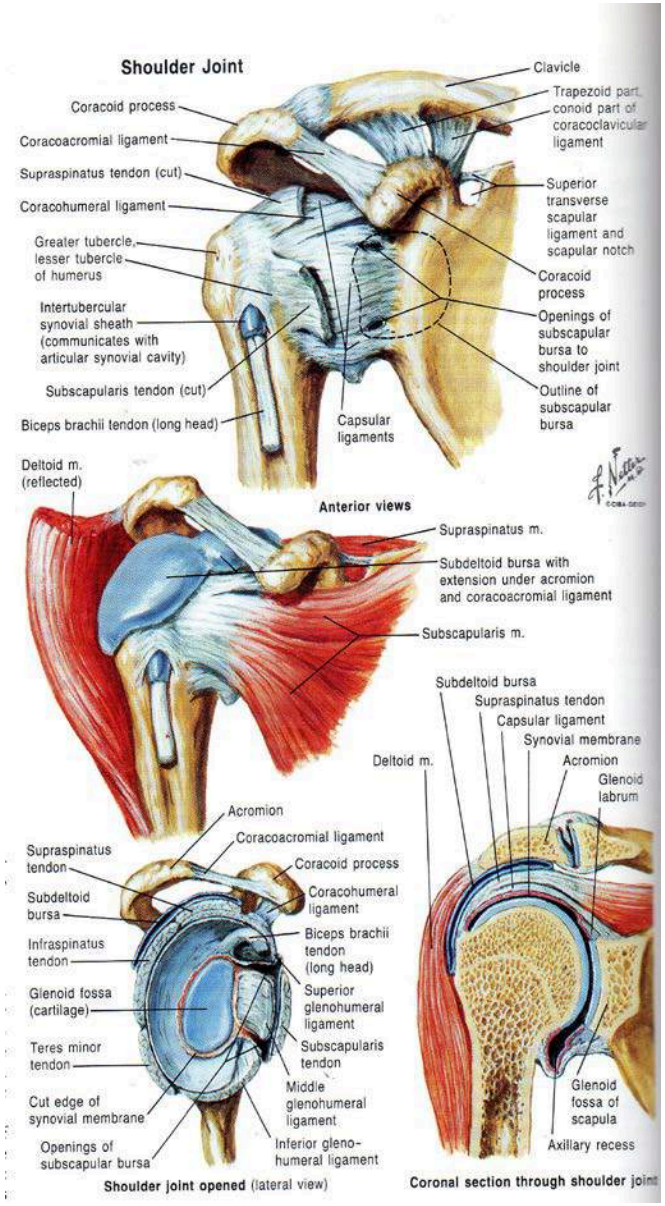
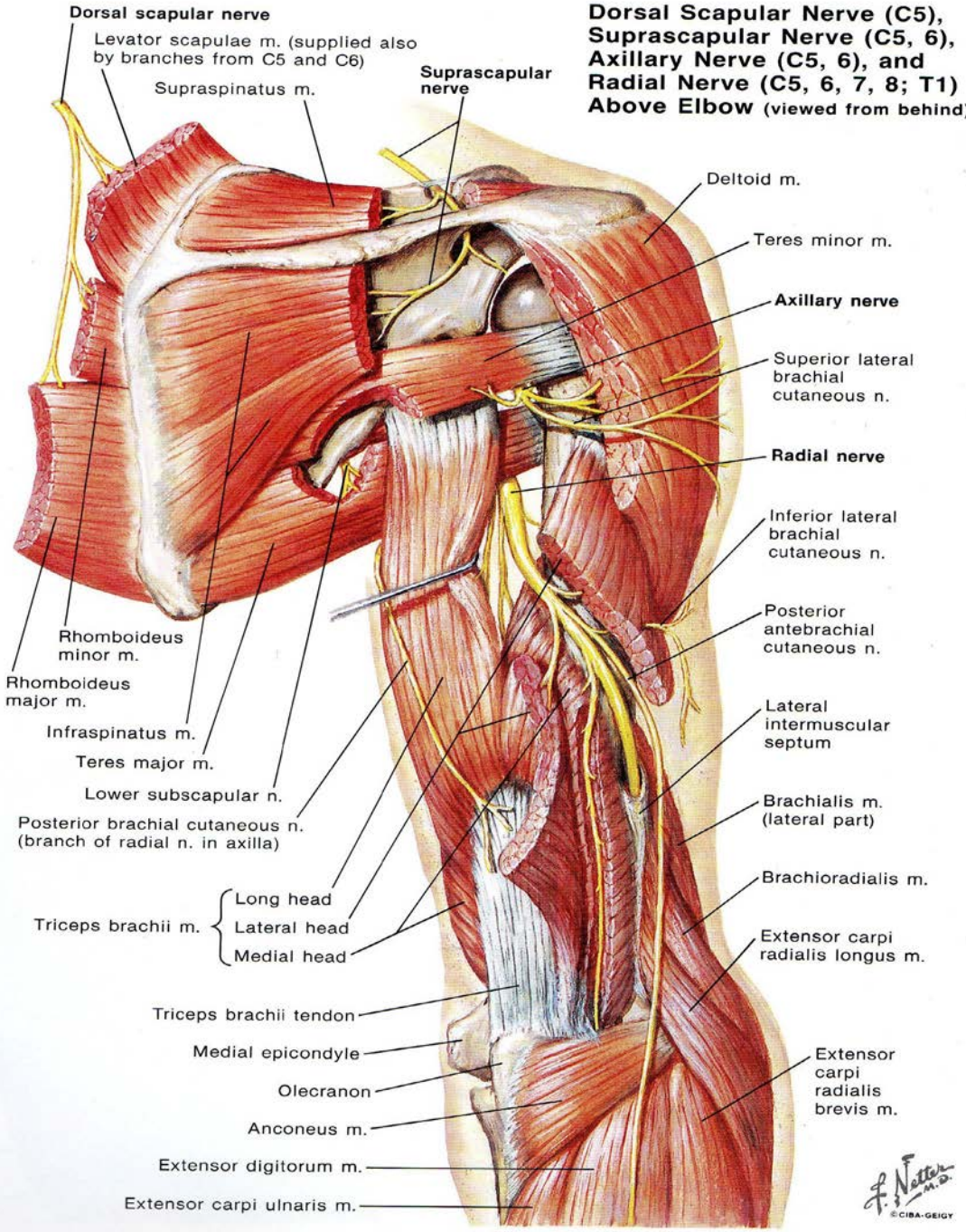
Summary
Of
Shoulder Injuries And Treatment


Shoulder Joint
Clavicle
Trapezoid part, conoid part of coracoclavicular ligament
Coracoid process
Coracoacromial ligament
Supraspinatus tendon (cut)
Coracohumeral ligament
Greater tubercle, lesser tubercle of humerus
Intertubercular synovial sheath (communicates with articular synovial cavity)
Subscapularis tendon (cut)
Biceps brachii tendon (long head)
Superior transverse scapular ligament and scapular notch
Coracoid process
Openings of subscapular bursa to shoulder joint
Outline of subscapular bursa
Capsular ligaments
Anterior views
Deltoid m. (reflected)
Supraspinatus m.
Subdeltoid bursa with extension under acromion and coracoacromial ligament
Subscapularis m.
Subdeltoid bursa
Supraspinatus tendon
Capsular ligament
Synovial membrane
Deltoid m.
Acromion
Glenoid labrum
Acromion
Coracoacromial ligament
Supraspinatus tendon
Coracoid process
Subdeltoid bursa
Coracohumeral ligament
Infraspinatus tendon
Biceps brachii tendon (long head)
Glenoid fossa (cartilage)
Superior glenohumeral ligament
Teres minor tendon
Subscapularis tendon
Middle glenohumeral ligament
Cut edge of synovial membrane
Openings of subscapular bursa
Inferior gleno-humeral ligament
Glenoid fossa of scapula
Axillary recess
Shoulder joint opened (lateral view)
Coronal section through shoulder joint

Dorsal Scapular Nerve (C5), Suprascapular Nerve (C5, 6), Axillary Nerve (C5, 6), and Radial Nerve (C5, 6, 7, 8; T1) Above Elbow (viewed from behind)



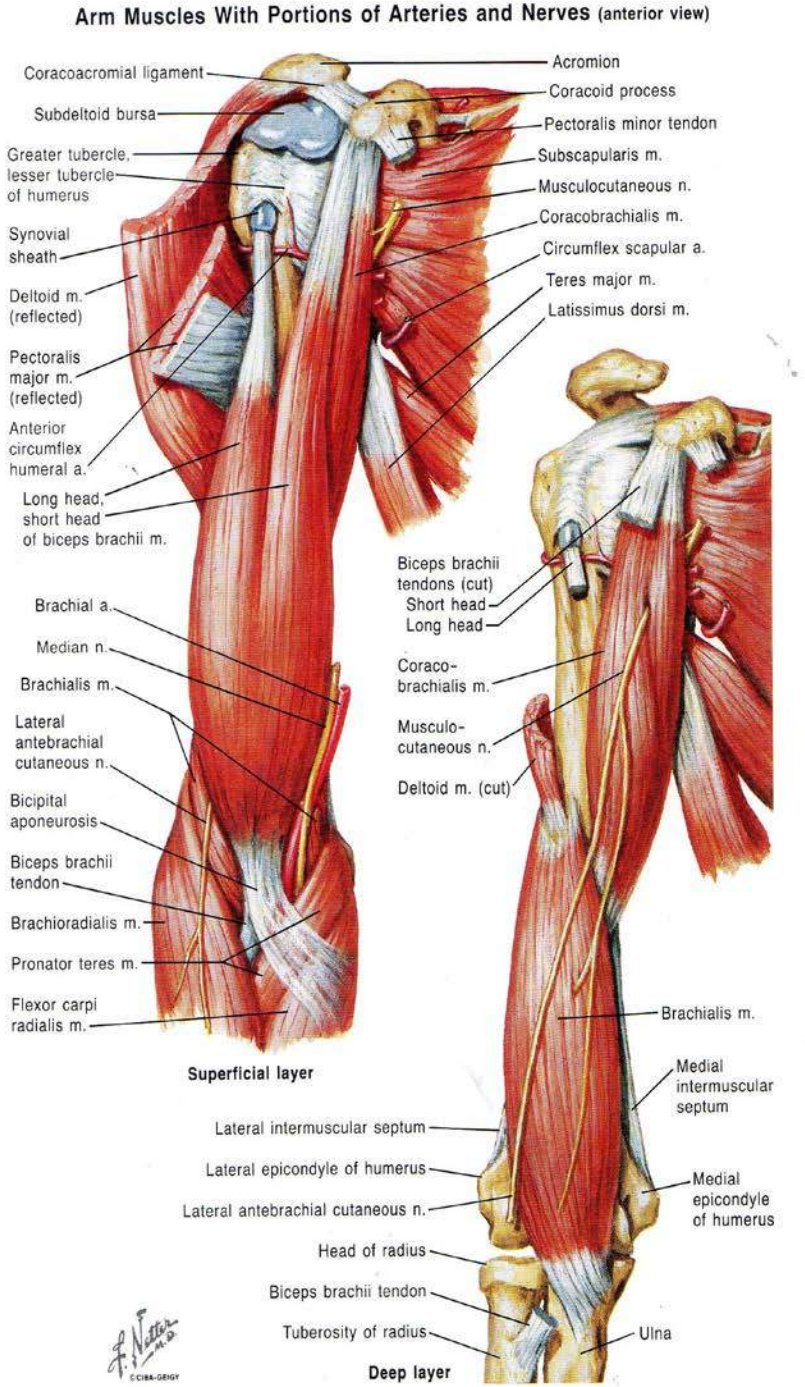
Tendinitis/Overuse

- ***No wasting***
- ***No deformity***
- ***No swelling***
- ***No redness***
- ***Tight or knotted shoulder blade or neck muscles***

Muscle Strain

- ***No wasting***
- ***No deformity***
- ***No swelling***
- ***No redness***
- ***Trigger point away from shoulder joint***

Shoulder Bursitis


Arm Muscles With Portions of Arteries and Nerves (anterior view)
Coracoacromial ligament
Subdeltoid bursa
Greater tubercle, lesser tubercle of humerus
Synovial sheath
Deltoid m. (reflected)
Pectoralis major m. (reflected)
Anterior circumflex humeral a.
Long head, short head of biceps brachii m.
Brachial a.
Median n.
Brachialis m.
Lateral antebrachial cutaneous n.
Bicipital aponeurosis
Biceps brachii tendon
Brachioradialis m.
Pronator teres m.
Flexor carpi radialis m.
Superficial layer
Acromion
Coracoid process
Pectoralis minor tendon
Subscapularis m.
Musculocutaneous n.
Coracobrachialis m.
Circumflex scapular a.
Teres major m.
Latissimus dorsi m.
Biceps brachii tendons (cut)
Short head
Long head
Coraco-brachialis m.
Musculo-cutaneous n.
Deltoid m. (cut)
Brachialis m.
Medial intermuscular septum
Lateral intermuscular septum
Lateral epicondyle of humerus
Lateral antebrachial cutaneous n.
Medial epicondyle of humerus
Head of radius
Biceps brachii tendon
Tuberosity of radius
Ulna
Deep layer
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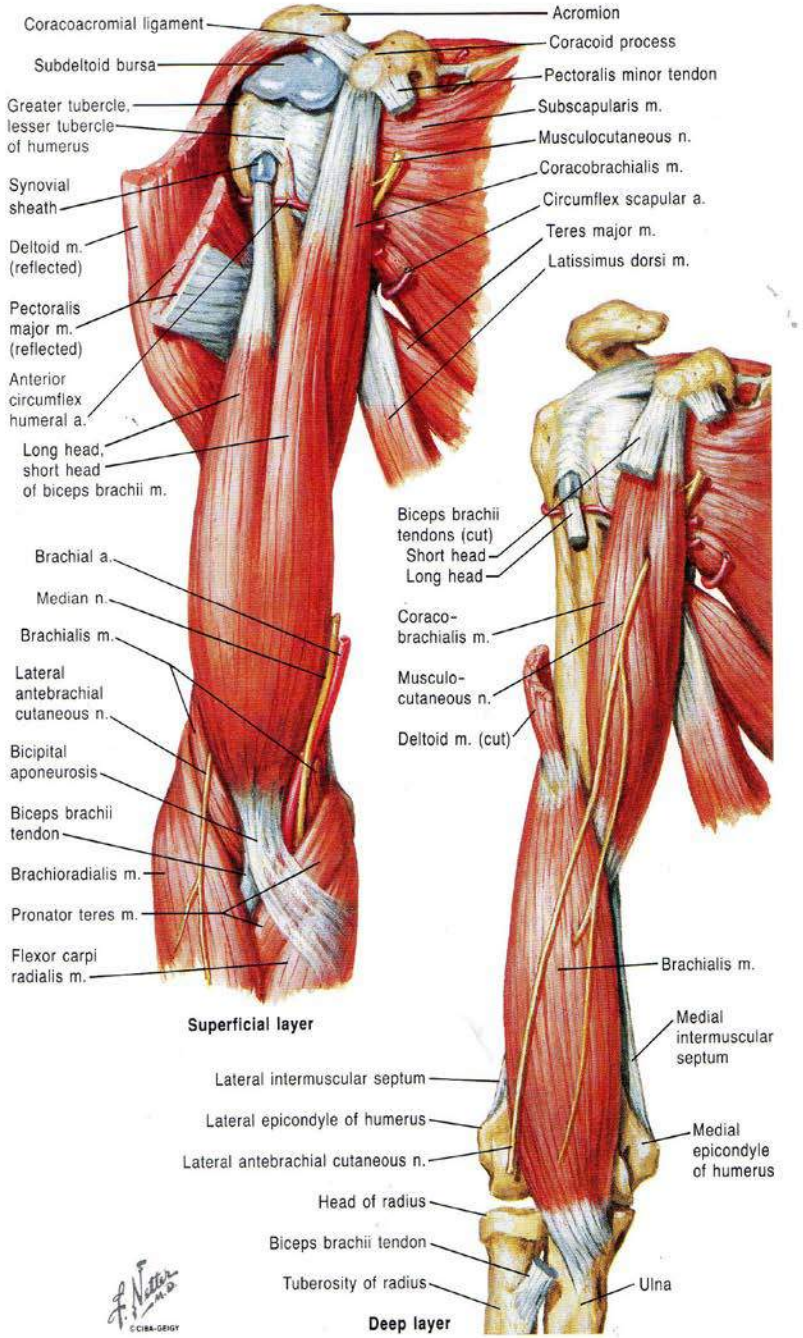
- ***Tenderness all over***
- ***Patient can press area of discomfort***
- ***May/may not have full ROM***
- ***May/may not have clicking***
- ***May/may not have crepitus***
- ***May have redness & swelling***
- ***Patient able to work to certain point, then pain starts***

Impingement

- ***Usually have clicking***
- ***Usually have snapping***
- ***Critical point within ROM where pain starts***
- ***Difficulty sleeping on affected side***

Arm Muscles With Portions of Arteries and Nerves (anterior view)

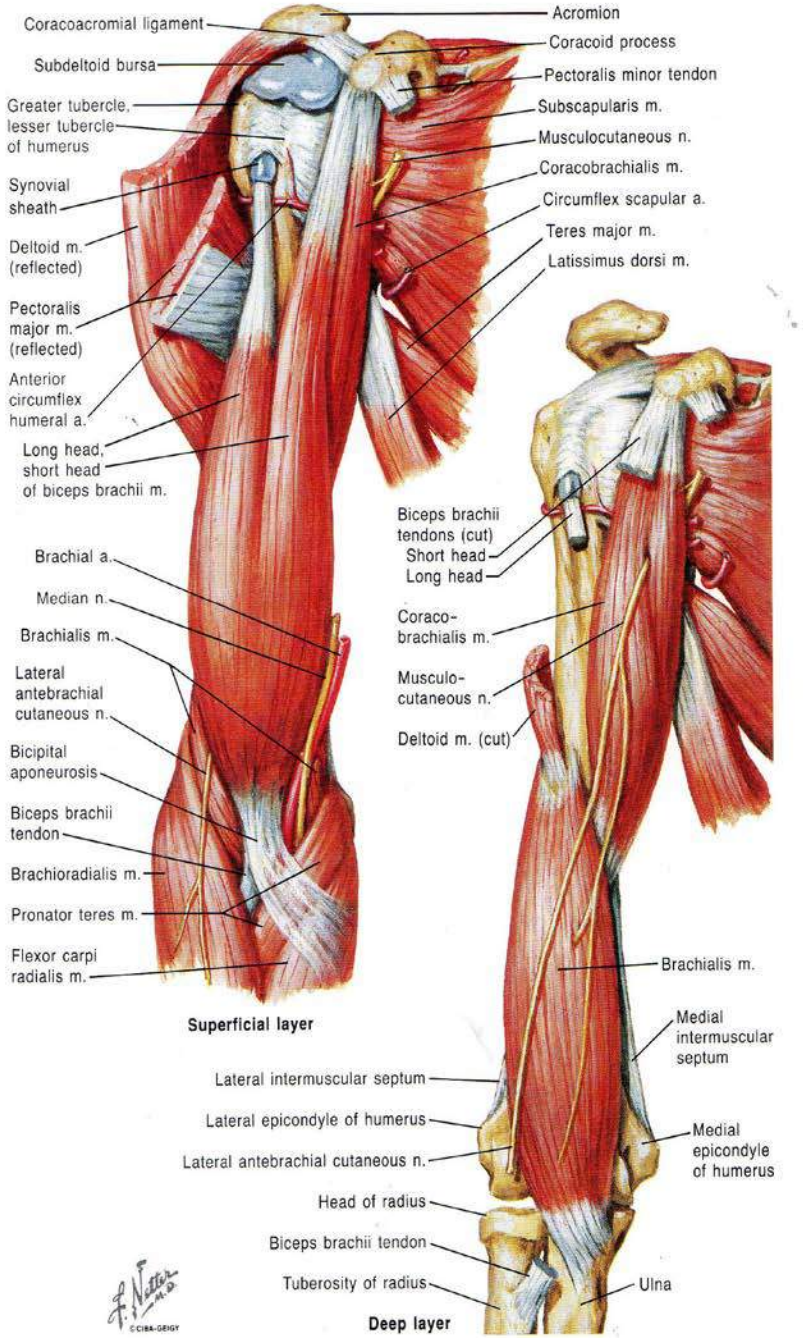


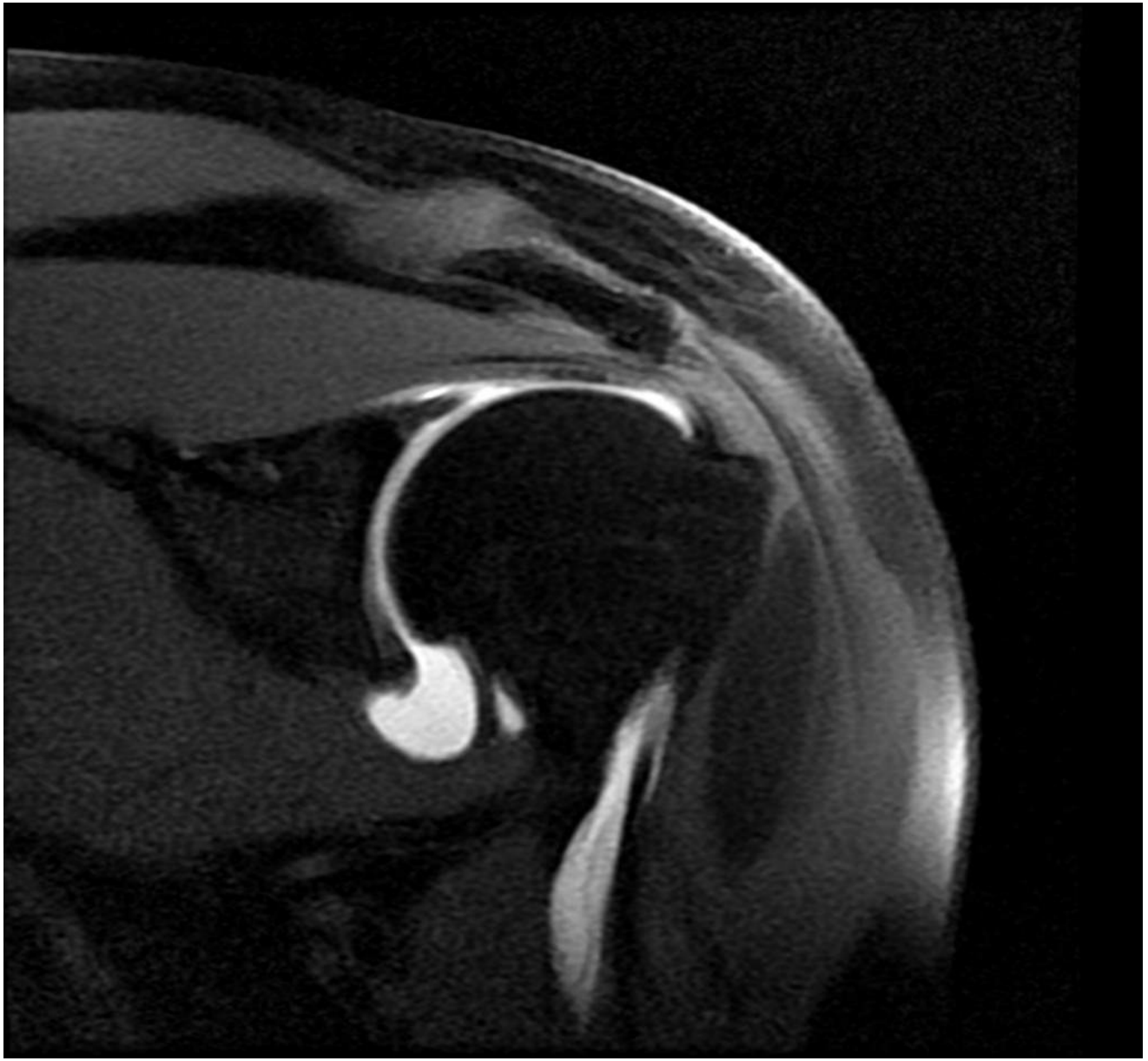
AC Arthritis

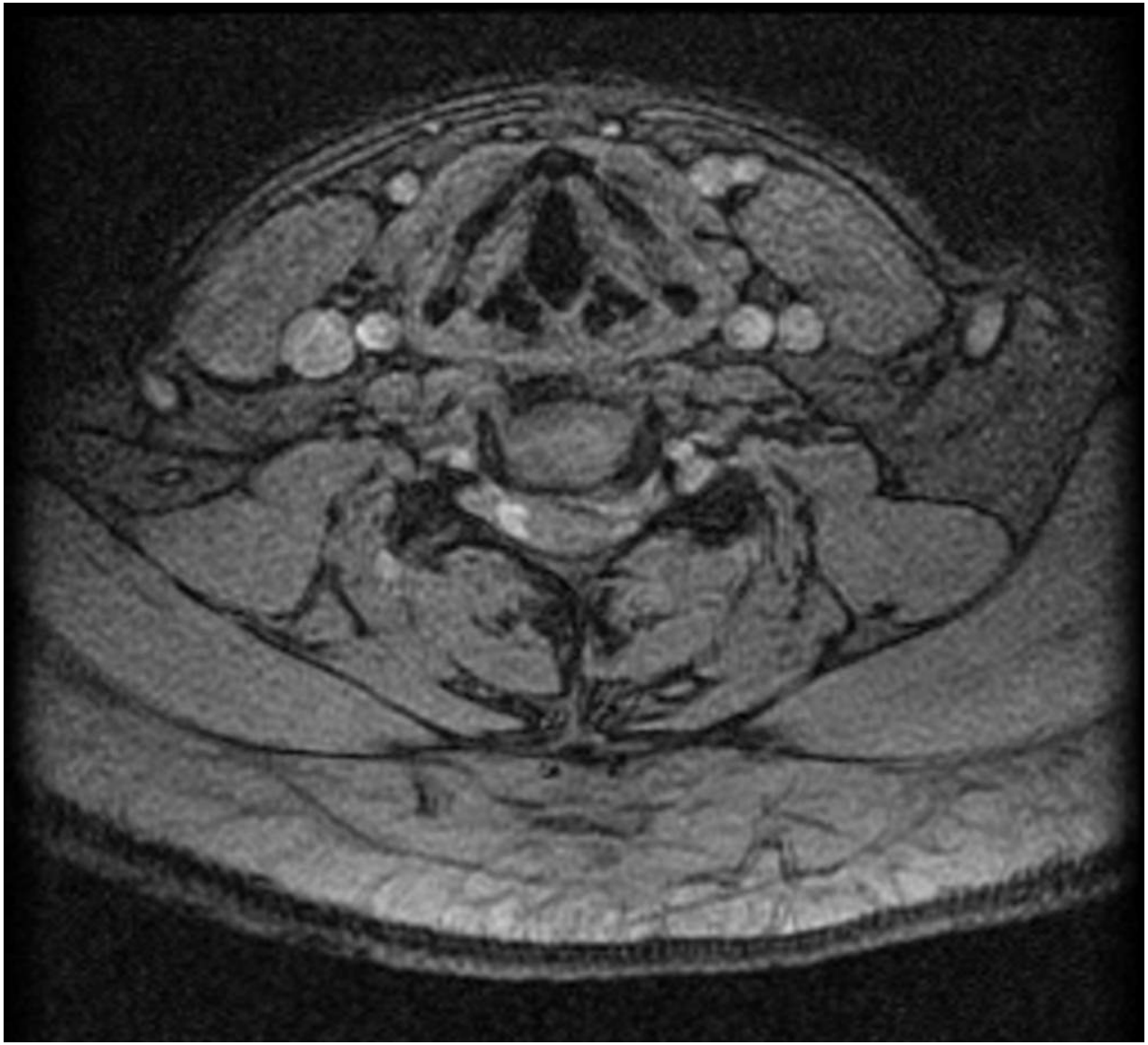
- ***Tenderness on top of shoulder***
- ***Difficulty combing hair***
- ***Difficulty moving hand to opposite shoulder***
- ***Prominent bump on top of shoulder***
- ***(if long duration)***

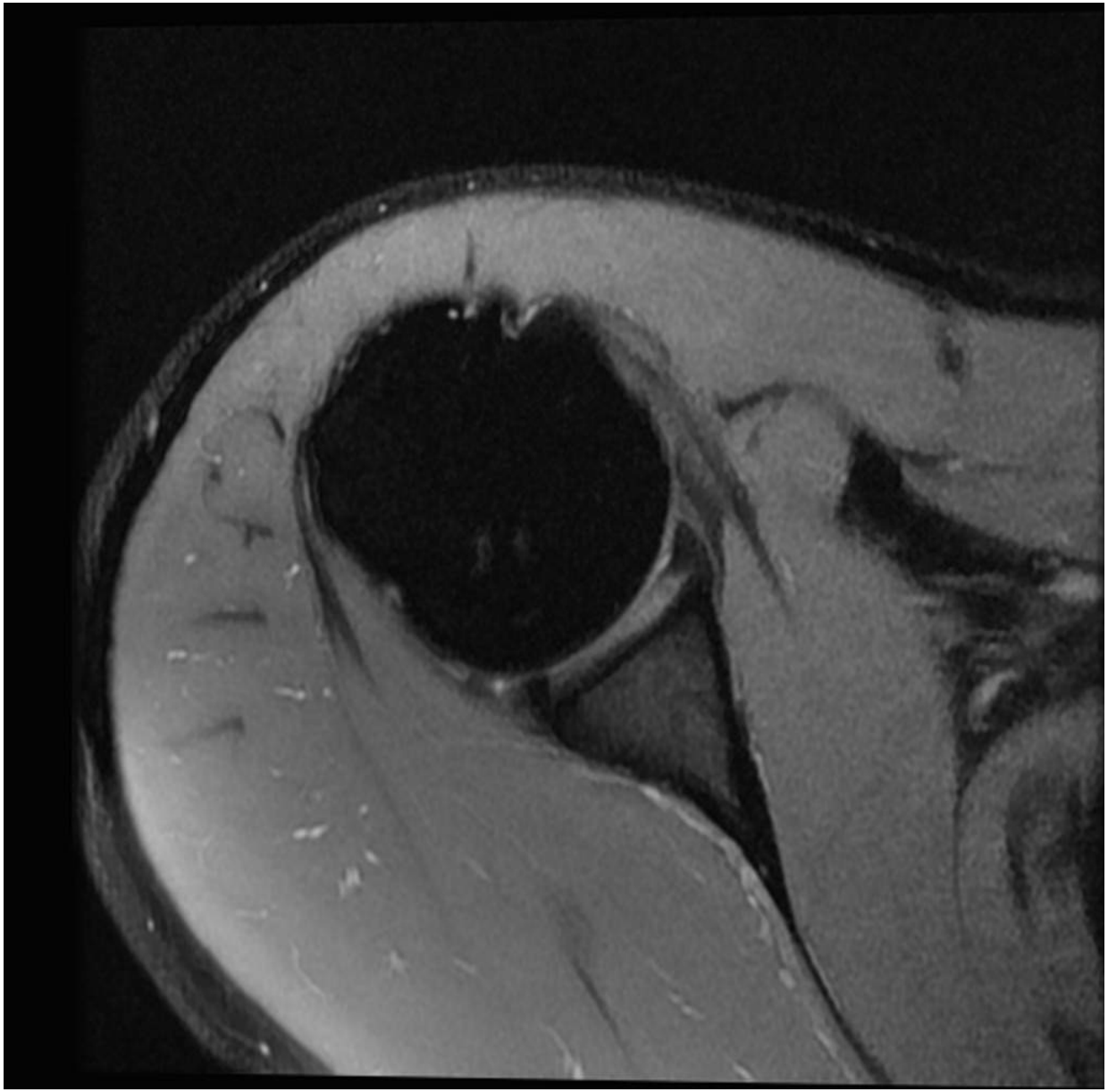
Rotator Cuff

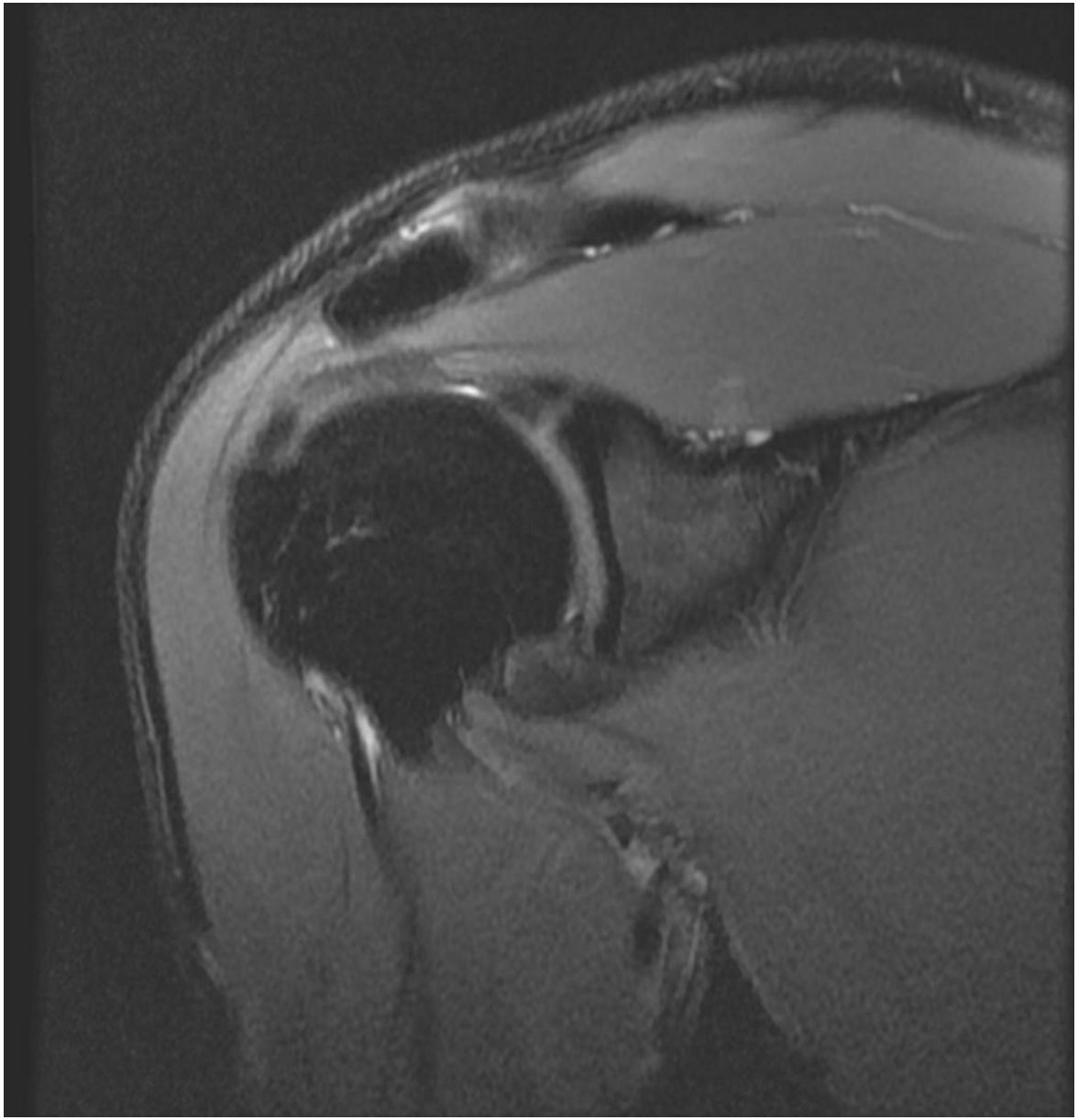
Arm Muscles With Portions of Arteries and Nerves (anterior view)

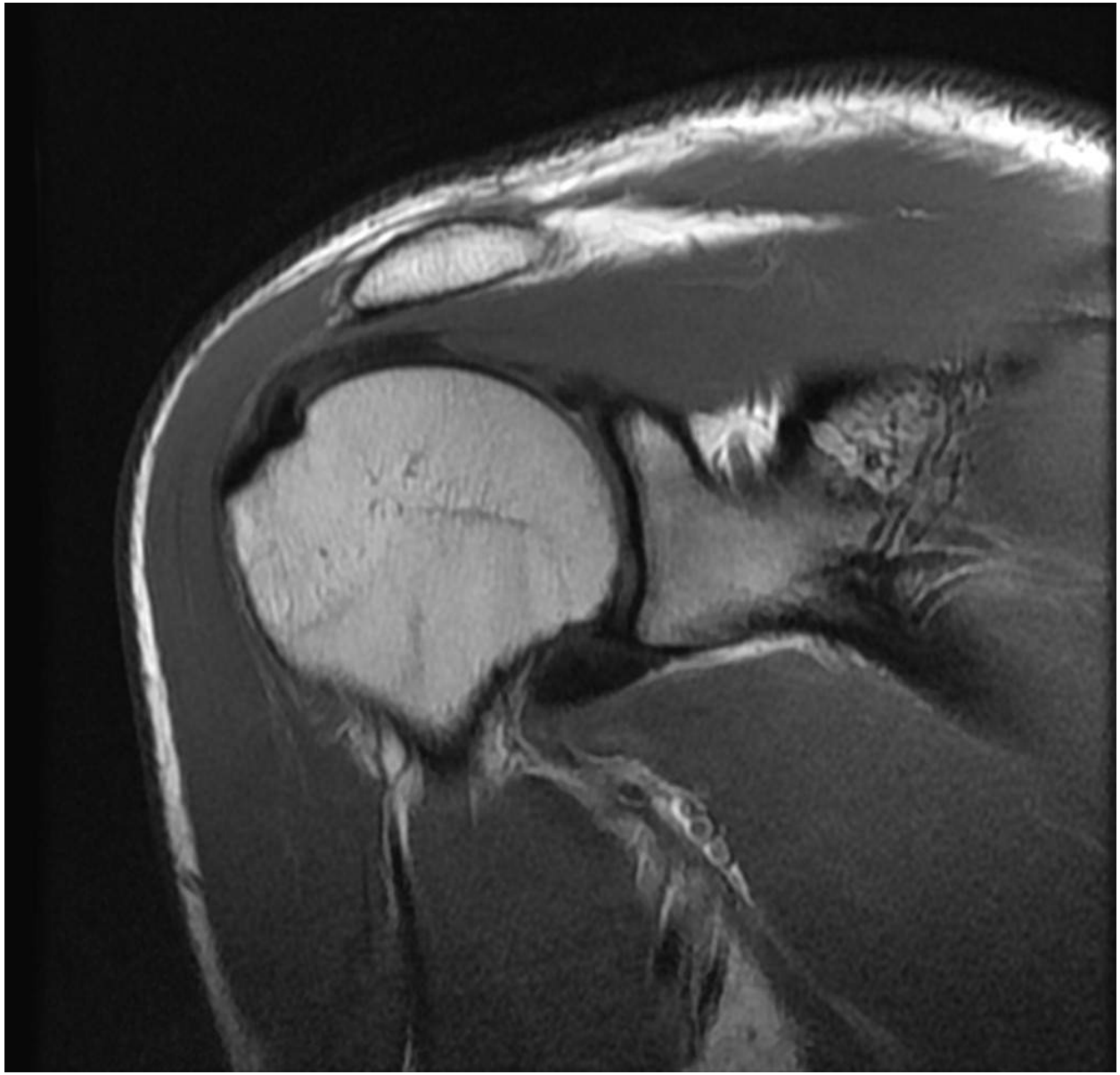


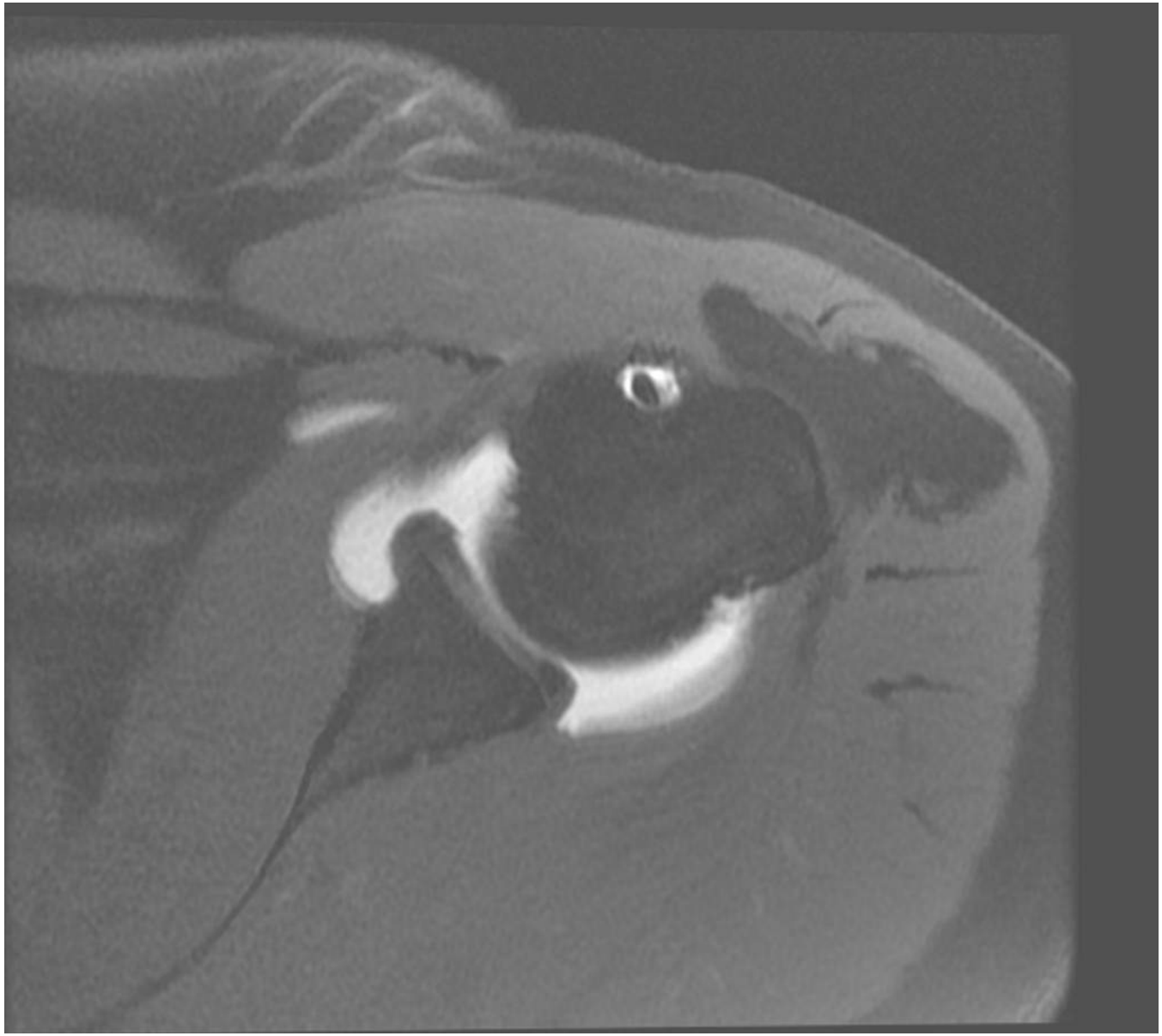








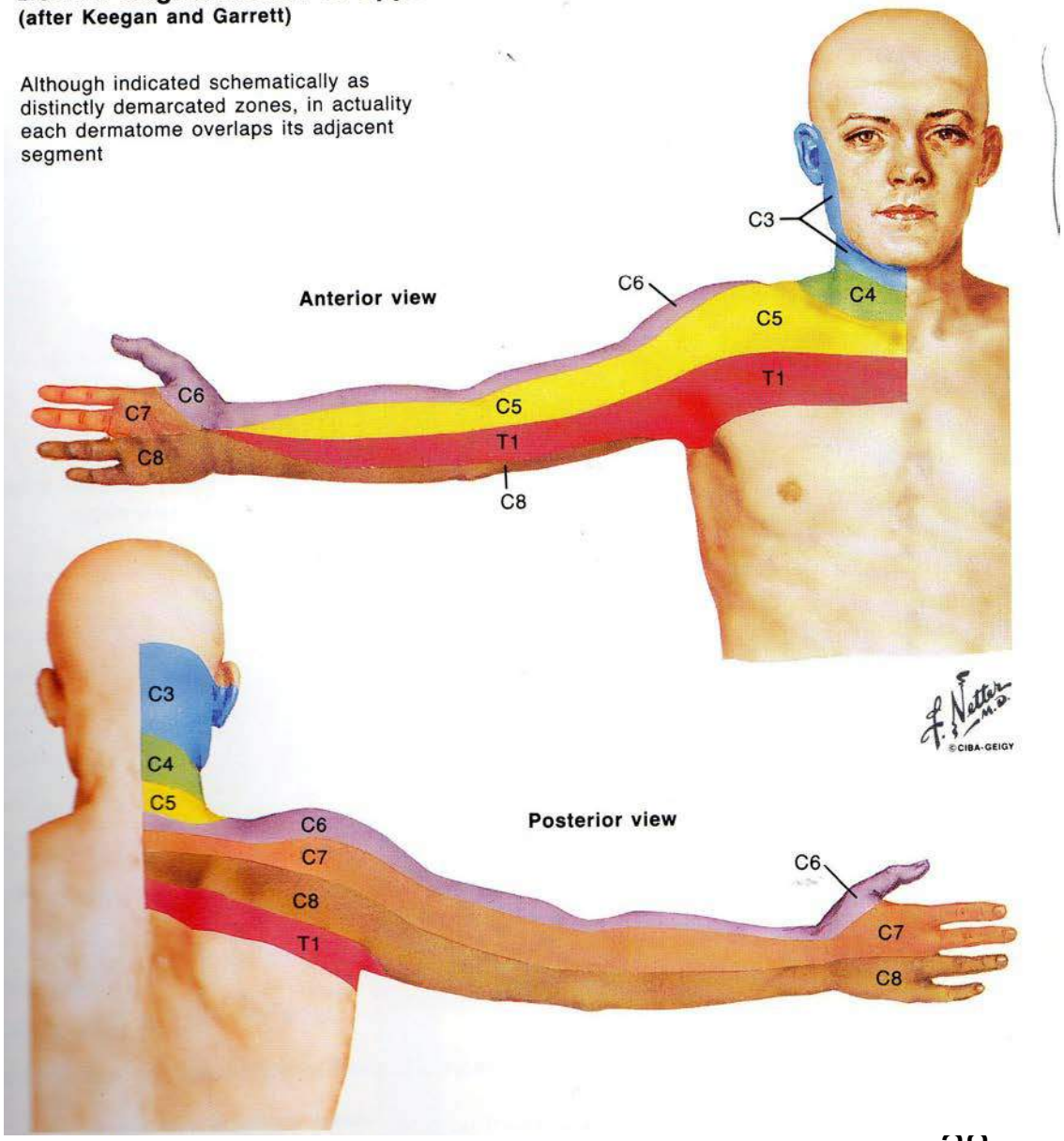




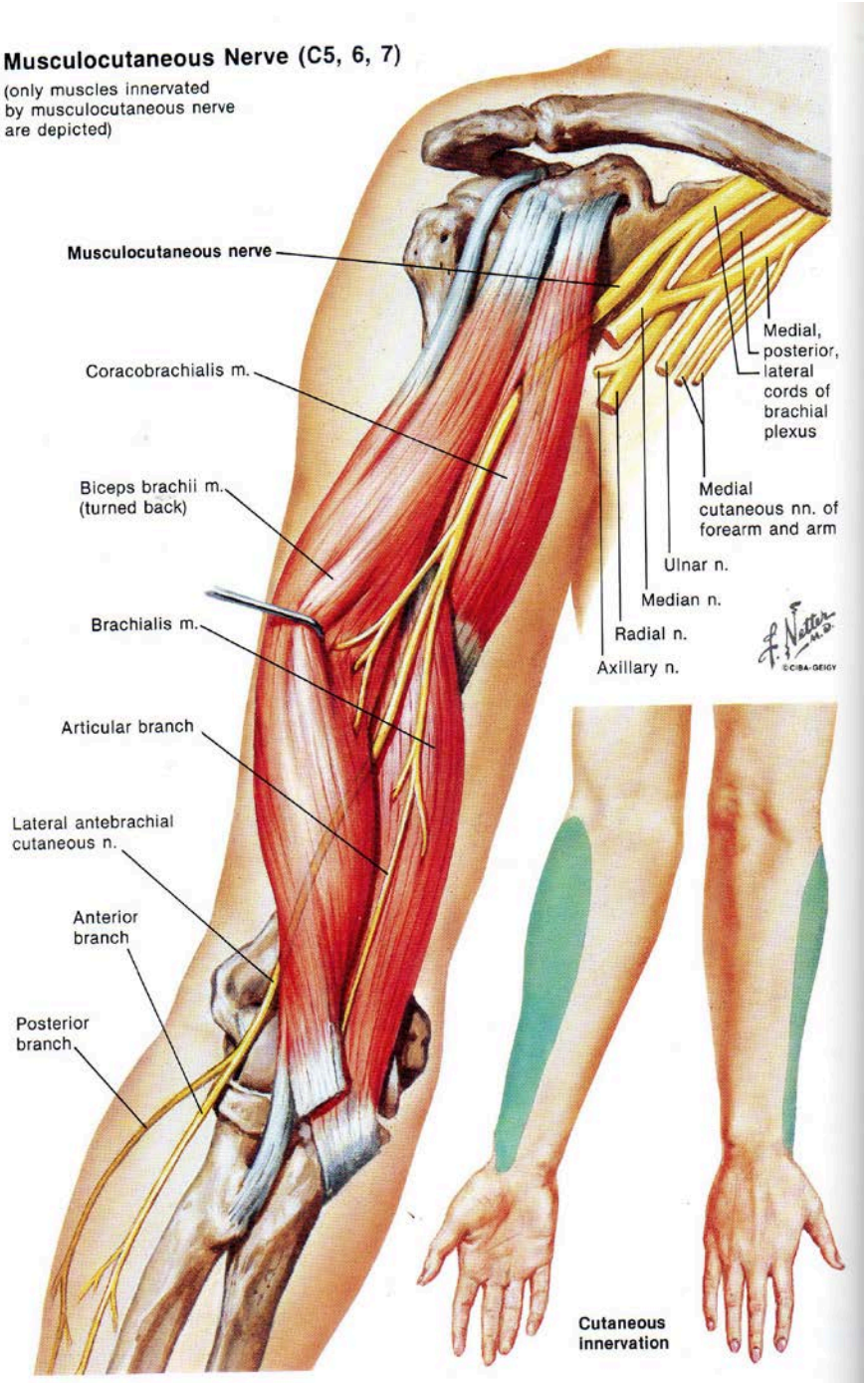
Cervical Disc Disease

Dermal Segmentation of Upper Limb
(after Keegan and Garrett)

Although indicated schematically as distinctly demarcated zones, in actuality each dermatome overlaps its adjacent segment



- ***Decreased strength***
- ***Weakness***
- ***Wasting of muscle***


Musculocutaneous Nerve (C5, 6, 7)
(only muscles innervated by musculocutaneous nerve are depicted)
Musculocutaneous nerve
Coracobrachialis m.
Biceps brachii m. (turned back)
Brachialis m.
Articular branch
Lateral antebrachial cutaneous n.
Anterior branch
Posterior branch
Medial, posterior, lateral cords of brachial plexus
Medial cutaneous nn. of forearm and arm
Ulnar n.
Median n.
Radial n.
Axillary n.
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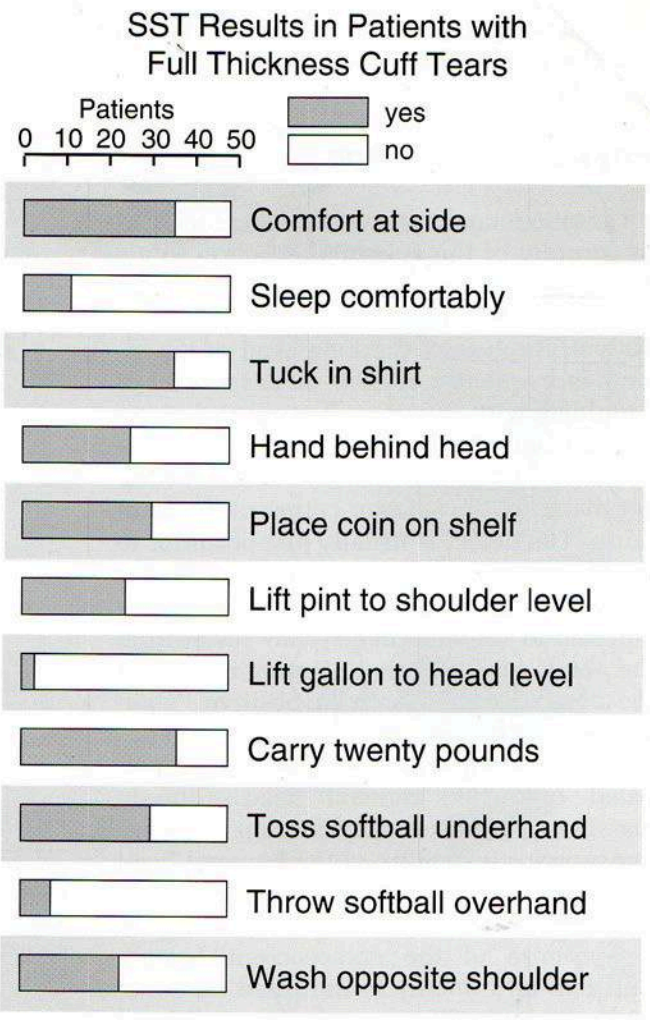
Cutaneous innervation

Which Physical Examination Tests Provide Clinicians With the Most Value When Examining the Shoulder?

<u>Conclusion</u>: Based on data from the original 2008 review and this update, the use of any single ShPE test to make a pathognomonic diagnosis cannot be unequivocally recommended.

- ***The Natural History of Asymptomatic Rotator Cuff Tears***
- ***A Three-Year Follow-up of Fifty Cases***


SST Results in Patients with
Full Thickness Cuff Tears
Patients
0 10 20 30 40 50
yes
no
Comfort at side
Sleep comfortably
Tuck in shirt
Hand behind head
Place coin on shelf
Lift pint to shoulder level
Lift gallon to head level
Carry twenty pounds
Toss softball underhand
Throw softball overhand
Wash opposite shoulder

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April 2013

What Constitutes Substantial Evidence?

Colleen S. Casey – WCJ Stockton

Ralph Zamudio – WCJ Van Nuys

Cirina A. K. Rose, Esq.

Dean Brown, Esq.

(The opinions expressed herein are solely those of the participants and are not the positions of the Department of Industrial Relations, the WCAB or any other entity.)

Physician must examine applicant

=

Substantial Evidence

Substantial Evidence Defined

"...[I]n order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability."

"...[A] medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess."

"…[A] medical report is not substantial evidence unless it sets forth the reasoning behind the physician's opinion, not merely his or her conclusions."

"…[A] a medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions."

The point is that the examination starts when the patient enters and/or exits the examining room, not just the time spent during actual hands-on examination.

If the active range of motion for flexion or abduction of the shoulder is only 90 degrees, the loss of motion in real life would affect the person's ability to perform overhead activities, such as combing hair or working above shoulder level.

AOE/COE

Causation of Injury

“Lighting Up” of underlying condition

- ***The natural progression of a non-industrial condition or disease.***
- ***A preexisting disability.***
- ***A post-injury disabling event, pathology.***
- ***Asymptomatic prior conditions, and***

Professionals in Workers' Comp. - Mid Valley

November 1, 2017

Manteca, CA.

View of the Knee From a QME Perspective

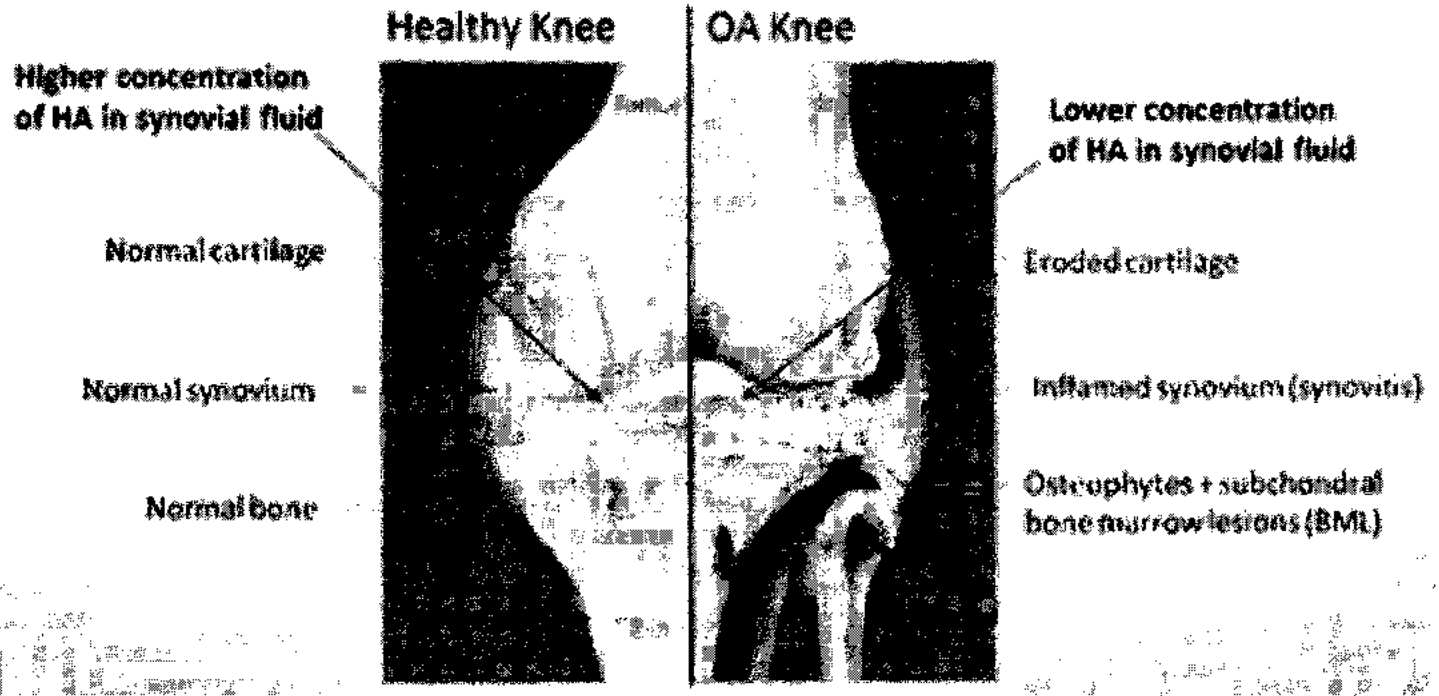
Speaker

Michael Charles, M.D.

Board Certified Orthopedic Surgeon

Newton Medical Group/ExamWorks

Osteoarthritis: A Progressive, Degenerative Joint Disease Involving Multiple Tissues



Causes of Osteoarthritis and Spinal Arthritis

There are a number of reasons why some people are particularly disposed to osteoarthritis. However, as with nearly all abnormal conditions affecting the body, it is likely that a combination of risk factors work together to cause osteoarthritis.

View Arthritis Videos

Repetitive trauma to the spine from repetitive strains caused by accidents, surgery, sports injuries, poor posture, or work-related activities are common causes of spinal arthritis.

Risk Factors for Spinal Arthritis

Athletes and people with jobs that require repetitive, and particularly heavy, motion have been found to be at greater risk. Other known risk factors for developing spinal arthritis include:

- **Aging**: steady and advanced aging of spinal structures, beginning in the 30s, often work-related
- **Gender**: osteoarthritis being more common in post-menopausal women (although below age 45, it is more common in males)
- **Excess weight**: causing more stress on weight-bearing joints and the spine, particularly during the middle age years
- **Genetics**: having a family history of osteoarthritis or congenital defects of joints, spine, or leg abnormalities
- **Associated diseases**: the presence of other associated diseases, infections, diabetes, and various other forms of circulating arthritis, such as rheumatoid arthritis or gout

Article continues below

When a specific cause of the osteoarthritis is unknown, as it is in most cases, it is referred to as primary osteoarthritis, which appears to be mostly due to aging. Aging leads to changes in cartilage and synovial fluid, as the tissue water content increases as the protein content decreases.

Long-term repetitive joint use has been shown to lead to joint inflammation with associated joint pain and swelling, eventually leading to the loss of cartilage.

When the cause of the osteoarthritis is known, it is referred to as secondary osteoarthritis, caused by a particular disease or condition, such as obesity, trauma or surgery to the joints, or abnormal joints at birth.

Importance of Treating Osteoarthritis

Patients with osteoarthritis who take an active role in their own treatment can prevent additional joint damage and usually will be able to continue with most of their normal activities.

The key to managing the condition is to get an accurate diagnosis and start early, proactive treatment. Most osteoarthritis treatments are focused on reducing the pain and inflammation associated with osteoarthritis and maintaining the joint mobility and flexibility needed to continue with necessary and desired activities.

It is clear that a combination of proper exercise, joint mobility, weight control, nutrition, and use of appropriate medication is required to control osteoarthritis.

More Osteoarthritis Info:

Cervical Osteoarthritis

Osteoarthritis Treatments

Facet Joint Disorders

- Read more: **Osteoarthritis Complete Treatment Guide**

A Spine-health.com Peer Reviewed Article

Written by **Charles D. Ray, MD**

Published: 06/07/2005

VIII. The Knee

70. EVALUATION OF THE INJURED KNEE

Brett W. Fischer, M.D.

HISTORY AND PHYSICAL EXAM

1. The evaluation of the injured knee begins with a detailed history. What are the important aspects of the history?

- Mechanism of injury—the position of the knee at the time of injury, the weight-supporting status, varus or valgus load, contact versus noncontact injury
- Noncontact injury with an audible "pop"—associated with anterior cruciate ligament (ACL) injury
- Contact injury with an audible "pop" more likely a collateral ligament injury, meniscal tear, or fracture
- Swelling—intraarticular swelling or effusion within the first 2 hours after trauma suggests hemarthrosis, whereas swelling that occurs overnight is an indication of acute traumatic synovitis.
- Pain—location, severity, type
- Instability—was there a sensation of the knee slipping out of joint, giving way, or deforming with weight bearing?
- Past history—previous injury or problems before current injury

2. What are the four most common causes of an acute hemarthrosis?

- ACL or posterior cruciate ligament (PCL) tear
- Peripheral tear of the medial or lateral meniscus
- Osteochondral fracture
- Capsular tear

3. What are the general principles of a knee examination?

The physical exam should be complete, precise, systematic, and carried out as soon after the injury as possible. Both lower extremities should be completely undressed to allow comparison. Always examine the uninjured knee first to obtain a baseline for comparison.

4. What are the three grades of ligamentous injuries according to O'Donoghue?

Grade I: mild sprain—a tearing of a few fibers, no instability, localized pain
Grade II: moderate sprain—incomplete tears with fibers still opposed, no pathologic laxity
Grade III: severe sprain—complete loss of integrity of the ligament with pathologic laxity.

5. Describe the three grades of pathologic laxity when assessing a ligament injury.

- I (0–4 mm of opening)
- II (5–9 mm)
- III (10–15 mm)

6. What is the terrible triad of O'Donoghue?

Medial meniscus tear

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Knee Conditions and Treatments

Osteoarthritis of the Knee

Osteoarthritis of the knee (OA Knee) is one of the five leading causes of disability among elderly men and women. The risk for disability from OA Knee is as great as that from cardiovascular disease. Here are some frequently asked questions about OA Knee.

What causes OA Knee?

OA Knee usually occurs in knees that have experienced trauma, infection or injury. A smooth, slippery, fibrous connective tissue called articular cartilage acts as a protective cushion between bones. Arthritis develops as the cartilage begins to deteriorate or is lost. As the articular cartilage is lost, the joint space between the bones narrows. This is an early symptom of OA Knee and is easily seen on X-rays.

As the disease progresses, the cartilage thins, becoming grooved and fragmented. The surrounding bones react by becoming thicker. They start to grow outward and form spurs.

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- Kim Stanowski, P.A.-C.

Patient Resources

- Frequently Asked Questions: Anterior Cruciate Ligament (ACL) Injuries
- Frequently Asked Questions: High Tibial Osteotomy
- Postoperative Instructions and Rehabilitation Protocols
- American Association of Hip and Knee Surgeons (AAHKS)
- Association Research Circulation Osseous (ARCO)
- Knee Society
- SaveYourKnees.org

Contact Information

The synovium (a membrane that produces a thick fluid that helps nourish the cartilage and keep it slippery) becomes inflamed and thickened. It may produce extra fluid, often known as "water on the knee," that causes additional swelling.

Over a period of years, the joint slowly changes. In severe cases, when the articular cartilage is gone, the thickened bone ends rub against each other and wear away. This results in a deformity of the joint. Normal activity becomes painful and difficult.

What factors increase the risk of developing OA Knee?

Several factors may increase the risk of developing osteoarthritis of the knee.

- **Heredity:** There is some evidence that genetic mutations may make an individual more likely to develop OA.
- **Weight:** Weight increases pressure on joints such as the knee.
- **Age:** The ability of cartilage to heal itself decreases as people age.
- **Gender:** Women who are older than 50 years of age are more likely to develop OA Knee than men.
- **Trauma:** Previous injury to the knee, including sports injuries, can lead to OA Knee.
- **Repetitive stress injuries:** These are usually associated with certain occupations, particularly those that involve kneeling or squatting, walking more than two miles a day, or lifting at least 55 pounds regularly. In addition, occupations such as assembly line worker, computer keyboard operator, performing artist, shipyard or dock worker, miner and carpet

Appointments
For more information or to make an appointment, call 860-679-6600 or 800-535-6232.

Office Hours
8 a.m. to 4:30 p.m.
Monday through Friday

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UConn Health
263 Farmington Avenue
Farmington, CT 06030-5352

Directions

Southington Medical Office
1115 West Street
Southington, CT 06489

Directions

or floor layer have shown higher incidence of OA Knee.

- **High impact sports:** Elite players in soccer, long-distance running and tennis have an increased risk of developing OA Knee.
- **Other illnesses:** Repeated episodes of gout or septic arthritis, metabolic disorders and some congenital conditions can also increase your risk of developing OA Knee.
- Other risk factors are being investigated, including the impact of vitamins C and D, poor posture or bone alignment, poor aerobic fitness and muscle weakness.

How is OA Knee diagnosed?

OA Knee can be diagnosed in two ways: patient-reported symptoms such as pain or disability or actual physical signs, such as the changes in the joint seen on X-rays. In most cases, both pathology and patient-reported symptoms are present. An evaluation of OA Knee includes a complete history and physical examination. The examination should cover:

- The involved limb.
- The spine.
- The blood and nervous system.
- The joints on either side of the knee, particularly the hip joint, which can also cause knee pain.
- Posture.
- Gait.

How is OA Knee treated?

Initial treatment is generally directed at pain management. OA Knee pain may have different causes, depending on the individual and the stage of

the disease. Thus, treatment is tailored to the individual.

A wide range of treatment options is available. You and your doctor should decide together on the course of treatment that's right for you. In general, treatment options fall into five major groups:

- **Health and behavior modifications**, such as patient education, physical therapy, exercise, weight loss, and bracing.
- **Drug therapies**, including simple pain relievers such as aspirin or nonsteroidal anti-inflammatory drugs, COX-2 specific inhibitors, opiates and stronger drugs for patients who do not respond to other drugs or treatments, and glucosamine and/or chondroitin sulfate.
- **Intra-articular treatments**, including corticosteroid injections or injections of hyaluronic acid (viscosupplementation).
- **Surgery**, including arthroscopy, osteotomy, and arthroplasty (joint replacement).
- **Experimental/alternative treatments** such as acupuncture, magnetic pulse therapy, vitamin regimes and topical pain relievers.

DISCUSSION PAPER
CUMULATIVE JOINT TRAUMA
IN THE DEVELOPMENT OF OSTEOARTHRITIS OF THE LUMBAR SPINE, HIPS, KNEES and ANKLES

Entitlement should not be claimed for Cumulative Joint Trauma alone. Entitlement, for VAC purposes, should be claimed for Osteoarthritis, with the affected joint identified (see Entitlement Eligibility Guideline on Osteoarthosis/Osteoarthritis).

INTRODUCTION

"Cumulative joint trauma" in this paper means physical trauma to a specific joint of the lumbar spine, hips, knees, or ankles from an increased load which occurs over a period of time following a repetitive activity, in the absence of an identifiable injury to that joint.

This discussion examines how repetitive cumulative joint trauma may influence the development of osteoarthritis (OA) in normal joints, anatomically abnormal joints, and injured joints of the lumbar spine and lower extremities, i.e. the weight-bearing joints. It excludes overuse injury to soft tissues.

A number of variables influences the relationship between cumulative joint trauma and OA of the weight-bearing joints. OA is a disease that evolves over a period of time, and is associated with the natural process of aging. Its development can be influenced by a variety of factors, including obesity, congenital joint abnormalities, and incidents of direct injury or trauma.

PLEASE NOTE: This discussion should be read in conjunction with the entitlement guideline on Osteoarthrosis/Osteoarthritis. An application for pension entitlement for OA requires that a "disability" from OA be present. For VAC pension purposes, a "disability" from OA is demonstrated when relevant signs and/or symptoms are present. X-ray evidence alone is insufficient to demonstrate a disability, as the condition must be symptomatic. X-ray findings do not correlate well with symptoms of OA ; therefore, while it is accepted that osteophytes and joint space narrowing are signs of OA, they do not mean that OA is symptomatic.

Medical-Legal Procedures
LC 4060, 4061, 4062, 4062.1, 4062.2

The following represents a summary and analysis of some of the most recent case decisions issued by the California Supreme Court, California Court of Appeal, and the Workers' Compensation Appeals Board, and Statutes which the Editor believes is significant to the Medical-Legal process, as well as the practice of Workers' Compensation law generally. The summaries are only the Editor's interpretation, analysis, and legal opinion, and the reader is encouraged to review the original case decision in its entirety.

Practitioners should proceed with caution when citing to this panel decision and should also verify the subsequent history of the decision. WCAB panel decisions are citeable authority, particularly on issues of contemporaneous administrative construction of statutory language [see Griffith v. WCAB (1989) 209 Cal. App. 3d 1260, 1264, fn. 2, 54 Cal. Comp. Cases 145]. However, WCAB panel decisions are not binding precedent, as are en banc decisions, on all other Appeals Board panels and workers' compensation judges [see Gee v. Workers' Comp. Appeals Bd. (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cases 236]. While WCAB panel decisions are not binding, the WCAB will consider these decisions to the extent that it finds their reasoning persuasive [see Guitron v. Santa Fe Extruders (2011) 76 Cal. Comp. Cases 228, fn. 7 (Appeals Board En Banc Opinion)]. Panel Decisions which are designated as "Significant" by the WCAB, while not binding in workers compensation proceedings, are intended to augment the body of binding appellate court and en banc decision and is limited to panel decisions involving (1) issue(s) of general interest to the workers' compensation community, especially a new or recurring issue about which there is little or no published case law; and (2) upon agreement en banc of all commissioners on the significance and importance of the issues presented and resulting decisions. (See Elliot v. WCAB (2010) 182 Cal.App. 4th 355, 361, fn. 3, 75 CCC 81; Larch v. WCAB (1999) 64 CCC 1098, 1099-1100 (writ denied).

I. General Discussion.

Resolving issues involving **MEDICAL LEGAL PROCEDURES** starts with three questions: (1) What is the Date Of Injury; (2) Is Applicant Unrepresented or Represented; and (3) What is the Issue Being Contested, (AOE/COE, PD, TD/ Entitlement to Job Displacement Benefits).

This presentation is limited to DOI post 1/1/05. However, with regards to pre-1/1/05 DOI, the procedures will depend on the DOI to determine the applicable statutory procedures.

Admissible medical opinions are limited to those of the Treater and PQME/AME pursuant to the procedures contained in Labor Codes 4060, 4061, 4062, 4062.1, 4062.2, 4610, AD Rule 32(b) and other applicable AD Rules. Issues involving medical treatment are limited to the UR/IMR process. (See generally, UR/IMR Outline, and *Lab. Code §§4610, 4610.1, 4610.5, 4610.6, 4616.3, 4616.4)*

II. Admissible Evidence

Procedures to obtain admissible evidence to establish an entitlement to PD/TD or medical treatment has been the subject of considerable litigation during the past decade. Now in large part due to the decisions of (1) *Batten v. WCAB (2015) 241 Cal. App. 4th 1009; 194 Cal. Rptr. 3d 511; 80 Cal. Comp. Cases 1256; 2015 Cal. App. LEXIS 964 (Court of Appeal Published), (2) Dubon v. World Restoration Inc., SCIF (2014) 79 CCC 1298, 79 CCC 566, 79 CCC 313, 42 CWCR 219 (En Banc Decision), and (3) Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418; 2014 Cal. Wrk. Comp. LEXIS 41 (En Banc Decision)* many of these issues have been resolved.

A. Admissible Evidence to establish PD/TD.

The law appears clear that the only medical evidence from the treating physician or secured through medical-legal procedures (LC 4060, 4061, 4062, et seq,) are admissible to establish applicant entitlement to PD/TD, and to establish injury.

Labor Code sections 4050, 4064(d), 4605 and 5701 do not provide an alternate procedure for a party to obtain admissible medical evidence.

Batten v. WCAB (2015) 241 Cal. App. 4th 1009; 194 Cal. Rptr. 3d 511; 80 Cal. Comp. Cases 1256; 2015 Cal. App. LEXIS 964 (Court of Appeal Published)

Applicant sustained injury to her jaw, shoulders, knees, neck, and low back arising out of and occurring in the course of her employment as a registered nurse. She also claims she sustained a psychiatric injury as a result of the physical injuries. The parties selected an Agreed Medical Evaluator in psychiatry. The physician found the applicant's psychiatric injury was not predominantly caused by her employment. The Worker's Compensation Judge authorized the applicant to obtain their own qualified expert in psychology at her own expense pursuant to section 4064(d). The physician selected by the applicant opined that 51% of applicant's psychiatric condition was due to work-related injuries and therefore that the applicant had sustained an industrial psychiatric injury. The matter proceeded to trial with the WCJ finding the medical report of the physician obtained pursuant to LC 4064(d) to be admissible, the better reasoned and more persuasive report, and that therefore the applicant had sustained a psychiatric injury. Defendant filed a petition for reconsideration arguing the report was not admissible as not secured pursuant to medical-legal procedures pursuant to Labor Code Sections 4060, 4061, 4062, 4062.1 4062.2.

See also, Tenet/Centinela Hospital Medical Center v. WCAB (2000) 65 CCC 477, treatment dispute involving discharged and need for further care required applicant to follow medical-legal procedures pursuant to LC 4061/62 in effect in 2000.

See also, accord, Ward v. City of Desert Hot Springs (2006) 34 CWCR 266, 71 CCC 1313 (WCAB Significant Panel Decision) where the WCAB upheld the WCJ noting the limiting language contained in LC 4060(c) and 4062.2(a) which provides that medical evaluations "shall be obtained only" by the procedures contained in 4060 & 4062.2, without mention of 4064. The WCAB noted the conflict between 4064(d) and 4062.2 was irreconcilable and therefore the newly amended sections of 4060 and 4062.2 must prevail over the older section of 4064. See also, Cortez v. WCAB (2006) 136 Cal.App.4th 596, 71 CCC 155 in which applicant attempted to secure medical-legal opinions under LC sections 4050 and/or 5701, and both held improper and therefore reports inadmissible on a pre-SB-899 med-legal case. The only way in which to obtain an admissible med-legal report is pursuant to LC 4062 et. seq.

The Board noted that section 4605 is contained in article 2 of chapter 2 of part 2 of division 4 of the Labor Code, which is titled "Medical and Hospital Treatment." Considering this context, the Board concluded that the term "consulting physician" in section 4605 means "a doctor who is consulted for the purposes of discussing proper medical treatment, not one who is consulted for determining medical-legal issues in rebuttal to a panel QME." We agree with the Board. Section 4605 provides that an employee may "provide, at his or her own expense, a consulting physician or any attending physicians whom he or she desires." When an employee consults with a doctor at his or her own expense, in the course of seeking medical treatment, the resulting report is admissible." Batten v. WCAB (2015) 241 Cal. App. 4th 1009; 194 Cal. Rptr. 3d 511; 80 Cal. Comp. Cases 1256; 2015 Cal. App. LEXIS 964 (Court of Appeal Published)

Editor's Comments: While the holding in Batten appears to put to rest securing a privately retained medical-legal report not secured pursuant to Labor Code Sections 4060, 4061, 4062, 4062.1 4062.2 for the purpose of establishing injury and arguably entitlement to PD, Batten left unaddressed securing a medical report for purposes of discussing proper medical treatment. But see, Dubon v. World Restoration Inc., SCIF (2014) 79 CCC 1298, 79 CCC 566, 79 CCC 313, 42 CWCR 219 (En Banc Decision), and Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418; 2014 Cal. Wrk. Comp. LEXIS 41 (En Banc Decision)

Therefore, LC section 4050, 4064(d), 4605 and 5701 all appear to be without consequence and of no real value post Batten which limits admissible medical evidence to that secured from the PTP and through the med-legal process, and as supplemented by VR evidence in establishing WPI and the resulting award of PD. But note that Batten appears to be in direct conflict with the Supreme Court's decision in Valdez v. WCAB (11/14/13, Cal. Supreme Court) 57 Cal.4th 1231, 78 CCC 1209.

The WCAB granted reconsideration and issued an opinion and decision concluding the report was not admissible and the WCJ should have relied on the report of the Agreed Medical Evaluator. The board concluded that LC 4064 (d) provides that medical legal evaluations obtained outside the procedures of 4060, 4061, 4062, 4062.1 4062.2 are not admissible. Applicant filed a petition for writ of review.

Court of Appeal, affirming WCAB decision, held that medical evaluations from physician retained by applicant at applicant's own expense pursuant to Labor Code § 4064(d) are (1) inadmissible before WCAB pursuant to Labor Code § 4061(i); and (2) that "plain and unambiguous language" of Labor Code § 4061(i) bars admissibility of privately retained physicians; and (3) that Labor Code § 4605 authorizing employees to obtain at their own expense "a consulting physician or any attending physicians whom he or she desires" refers to physician consulted for purposes of discussing proper medical

treatment, whose reports are, therefore, admissible, but does not permit admission of report by physician retained solely for purpose of rebutting opinion of agreed medical evaluator as to injury or disability.

Valdez v. WCAB (11/14/13, Cal. Supreme Court) 57 Cal.4th 1231, 78 CCC 1209

Applicant claimed injuries to a wide variety of body parts arising out of her employment as a demonstrator for Warehouse Demo Services for the period ending on 11/02/09. Defendant admitted injury to the back, right hip and neck. Applicant was sent for treatment to the employer's MPN. However, on referral from applicant's attorney, the applicant began treating with Dr. Nario, a non-MPN physician. Ultimately, the matter was set for hearing on the issue of TD.

Editor's Comments: During the pendency of this case, the Governor signed into law SB863 which modified LC 4605 to provide as follows: "Nothing contained in this chapter shall limit the right of the employee to provide, at his or her own expense, a consulting physician or any attending physicians whom he or she desires. Any report prepared by consulting or attending physicians pursuant to this section shall not be the sole basis of an award of compensation. A qualified medical evaluator or authorized treating physician shall address any report procured pursuant to this section and shall indicate whether he or she agrees or disagrees with the findings or opinions stated in the report, and shall identify the basis for this opinion."

Editor's Comments: Surprisingly no one appears to have argued that such an outcome would now allow an injured worker with the financial ability to 'game the system' through shopping for that doctor, a concern clearly apparent in the subsequent decision of Batten. One might also question what impact this decision will have under the Affordable Care Act which might provide the economic resources to allow an injured worker to secure an opinion from an alternate treating physician? Note too that the Valdez Court deferred the issue of whether the defendant would be financially liable for the cost of unauthorized treatment procured outside the MPN.

At hearing, the applicant testified that her attorney had sent her to Dr. Nario because the treatment with Dr. Nagamoto (MPN physician) was not helping. There was however, no evidence that applicant had reported this complaint to either the claims examiner or defense counsel. Applicant further testified that she was receiving SDI benefits from April 7, 2010 through May 26, 2010 and continuing. Relying on the opinion of the non-MPN physician, the WCJ awarded TD from DOI through 2/10/10. In doing so, the WCJ expressly rejected defendant's argument that the "reports of the non-MPN doctors are inadmissible pursuant to Labor Code 4616.6."

The WCAB issued an en banc decision holding that where unauthorized treatment is obtained outside a (1) validly established, and (2) properly noticed MPN, that (3) reports from that non-MPN physician are inadmissible and therefore may not be relied upon.

On review the Court of Appeal reversed noting that had the legislature intended to exclude the reports of non-MPN physicians they could have so stated. Further, the Court noted that their decision was consistent with LC 4605, which authorizes an employee to provide, "at his own expense, a consulting physician or any attending physicians who he desires". The Court further stated that Labor Code 4616.6 was limited to independent medical review process within the MPN. The Court also wrote that a decision excluding a non-MPN physician would completely negate the employee's right to select his own treating physician pursuant to LC 4605. Further, the Court noted that defendant's reliance on *Tenet/Centinela Hospital Medical Center v WCAB (2000) 65 CCC 477* was misplaced as the holding in *Tenent* was not to exclude the report from review by the QME, but merely to require the applicant to comply with medical-legal procedures pursuant to LC 4061/62. The Court concluded that *Tenent* should be interpreted as one of inclusion not exclusion of evidence in that *Tenent* allowed the medical opinion of the prior PTP into evidence.

Thereafter, defendant sought review before the California Supreme Court. In affirming the Court of Appeal's decision, the California Supreme Court added that the legislative changes contained in SB-863 only served to confirm the limited application of LC 4616.6. Further, SB-863 did nothing to limit an employee's "right to seek treatment from doctors of their choice at their own expense, or to bar those doctors' reports from admission in disability hearings." Stated alternatively, SB-863 including specifically LC 4605 permits an employee to obtain consultation with privately retained physicians at their own expense and for the WCAB to consider that opinion in making an award of compensation.

B. Entitlement to Medical Treatment -- Limited to the UR/IMR Procedures.

Dubon v. World Restoration Inc., SCIF (2014) 79 CCC 1298, 79 CCC 566, 79 CCC 313, 42 CWCR 219 (En Banc Decision)

The applicant sustained successive injuries in 2003 and 2004 to various parts of body. The applicant underwent a course of treatment which included various diagnostic studies including EMG/NCV (positive for L4-5 radiculopathy), Lumbar MRI (positive for L4-5 disc protrusion) and a discogram (positive for L4-5 and L5-S1 discogenic pain). The PTP referred the applicant to Dr. Simpkins for evaluation regarding further treatment including the need for surgery. On July 1, 2013 Dr. Simpkins requested authorization for surgery. Defendant submitted the request for UR and thereafter the defendant's UR agent sent a denial letter to Dr. Simpkins. The evidence relied upon by the UR physician did not contain any report from the applicant PTP, only one report from the treating/evaluation surgeon Dr. Simpkins, no reports from the AME who had requested the discogram, nor the discogram report. The UR physician apparently was provided with 18 additional pages of medical records which were not specifically commented upon. The basis for the UR denial was the lack of documented imaging of nerve root compression; no evidence that conservative treatment had failed; and no documented condition/diagnosis for which spinal fusion was indicated. The WCJ found for the defendant holding that despite the procedural defects with defendant's UR described as "critical errors" any alleged procedural defects must be resolved through IMR, as the need for surgery involved an issue of medical necessity.

Editor's Comments: While Dubon I placed the burden on the defendant/claims adjuster to submit to the UR physician all relevant information necessary for UR physician to address the issue of medical necessity, Dubon II clearly places the burden on the applicant/applicant attorney to ensure timely submission by defendant, as well as that the defendant has submitted all relevant documentation/information to the UR physician and limits to review through the IMR process on the issue of medical necessity, absent an untimely UR submission by defendant.

But see, the dissenting opinion by Commissioner Sweeney who relying on the California Supreme Court decision of Sandhagen wrote "A treatment determination that does not comply with section 4610 is not a 'decision pursuant to section 4610,' and thus by definition is not a 'utilization review decision.' A utilization review decision is a necessary prerequisite for independent medical review, and by the terms of sections 4610 and 4610.5, only a dispute after a utilization review decision, i.e., a treatment determination that complies with section 4610, is resolved through independent medical review. Therefore, a dispute over a treatment determination without compliance with section 4610 is not a dispute over a utilization review decision pursuant to section 4610.5(a), and such a dispute is not subject to section 4610.5 independent medical review." Further, judicial review and decision based on substantial medical opinions is not contrary to the legislative intent behind the IMR process that medical necessity be determined by medical professionals rather than the judiciary. Succinctly, Commissioner Sweeney concluded her opinion writing "Section 4610 established a utilization review process with mandatory requirements. Section 4610.5 established a process of independent medical review of utilization review decisions. Treatment determinations that do not comply with section 4610 are not utilization review decisions and are not subject to independent medical review, controversies as to those determinations must be resolved by the WCAB pursuant to section 4604."

This editor is unaware of any Reg or Labor Code section that limits evidence/information that may be provided to the IMR physician to that which was available at the time the UR process was begun. The applicant therefore might be able to obtain/generate evidence after review of the UR determination to be used as rebuttal on IMR.

On reconsideration, the WCAB reversed the WCJ. The WCAB first confirmed that "IMR solely resolves disputes over the medical necessity of treatment requests" where the UR is not invalid. However, issues of timeliness and compliance with statutes and regulations governing UR are legal disputes within the jurisdiction of the WCAB. Second, the WCAB held "a UR decision is invalid if it is untimely or suffers from material procedural defects that undermine the integrity of the UR decision. Minor technical or immaterial defects are insufficient to invalidate a defendant's UR determination, rather a UR decision is invalid only if it suffers from material procedural defects that undermines the integrity of the UR decision. Last, where a defendant's UR is found invalid, the issue of medical necessity is not subject to IMR, but is to be determined by the WCAB based upon substantial medical evidence, with the employee having the burden of providing the treatment is reasonably required.

On further reconsideration the WCAB by En Banc decision reversed holding that medical necessity may only be addressed by the WCJ where the UR is untimely. In circumstances involving medical necessity the procedure is limited to the UR/IMR process and is not subject to expedited hearing

or other proceedings before the WCAB.

Edilberto Cerna Romero v. Stones and Traditions, State Compensation Insurance Fund, 2016 Cal. Wrk. Comp. P.D. LEXIS 142 (Board Panel Decision)

The applicant's PTP submitted an RFA for four different treatment modalities. The UR physician requested additional information pertaining to two of the treatment modalities and issued a decision within 14 days as required by Labor Code § 4610 as to all four of the treatment modalities. The WCJ reasoned that the UR physician should have issued a decision regarding the two treatment modalities for which no additional information was required within 5 days.

On reconsideration the WCAB disagreed holding that Rule 9792.9.1 provides that an RFA triggers the timelines for completing utilization review and does not contemplate different timelines for different treatment requests within a single RFA. Accordingly, the September 14, 2015 UR decision is timely as to all modalities requested as part of the RFA. See also, Favila v. Arcadia Health Care, Cypress Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 181 (Board Panel Decision) Labor Code § 4610(g)(1), 8 Cal. Code Reg. § 9792.9.1. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10; Sullivan On Comp, 7.35 Utilization Review – Time Limits.]

See also, accord, infra, Bodam v. San Bernardino County/Department of Social Services (2014) 79 CCC 1519, 2014 Cal.Wrk.Comp.LEXIS 156 (Significant Panel Decision) which held that a defendant is obligated to comply with all time requirements in conducting UR, including the timeframes for communicating the UR decision; (2) A UR decision that is timely made but is not timely communicated is untimely; (3) when a UR decision is untimely and therefore invalid, the necessity of the medical treatment at issue may be determined by the WCAB based upon substantial evidence. LC 4610(g)(1)-(3) requires that the decision be communicated within 24 hours for concurrent review and 2 days for prospective review. (Accord, Vigil v. Milan's Smoke Meats (SCIF) 2014 Cal.Wrk.Comp. LEXIS __)

See also, Stock v. Camarillo State Hospital, SCIF (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 471 (Board Panel Decision) (ADJ2426407/Oxnard) involving the request for a hospital bed for applicant with two level lumbar fusion who could not sleep in flat bed and had been sleeping in recliner for past four years. The WCAB upheld WCJ's determination that RFA from MPN doctor is subject to the UR/IMR process writing "Contrary to the applicant's contentions, by its adoption of the MPN system, the Legislature did not evidence the intent to preclude a defendant from seeking UR review of an MPN physician's request for authorization of medical treatment." Also reaffirming that Rule 9792.10.1(4)(A)-(F) provides that where the MTUS is "silent and there is no peer-review scientific and medical evidence, the reviewer may consider nationally recognized professional standards, expert opinion, generally accepted standards of medical practice and treatment that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious". See also, accord, opinion granting reconsideration for further consideration Hogenson v. Volkswagen Credit, Inc. AIG Claims San Diego, AJD2145168, (6/18/14 Oxnard District Office);

See also, Glendale Adventist Medical Center v. WCAB (Gibney) 79 CCC 1544, 2014 Cal.Wrk.Comp. LEXIS 158, where medical necessity proper issue at expedited hearing where UR untimely despite treatment for contested part of body where award of medical treatment was reasonable and necessary (LC 4600) to cure or relieve accepted part of body. See also, accord, Sanchez v. Enterpriase Rent-A-Car 2014 Cal.Wrk.Comp.P.D. LEXIS 596.

See also, Flores v. Hvolvoll-Johnson Construction 2014 Cal.Wrk.Comp.P.D. LEXIS 561, where defendant only raises jurisdiction/authority of WCAB to determine timeliness and medical necessity on reconsideration, the holding of WCJ on UR timeliness and medical necessity upon a finding of untimely UR will be upheld.

Bissett-Garcia v. Peace and Joy Center, Virginia Surety Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 174 (Board Panel Decision); Bissett-Garcia v. Peace and Joy Center, Virginia Surety Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 282 (Board Panel Decision);

On September 11, 2015, applicant wrote to defense counsel attaching a PR-2 report from primary treating physician. On the bottom of page 2 of the attached report the PTP wrote, "The patient requires home assistance with [activities of daily living]; 8 hours a day, 7 days a week for cooking, cleaning, self-grooming and transportation." On the transmittal letter, applicant's counsel wrote, "Please see the attached PR-2, treating doctor's report from Dr. Vincent J. Valdez 9/08/15. Requesting authorization from home assistance 8 hours a day, 7 days a week. We are asking that this be authorized upon receipt of this letter."

Despite the fact that this "request for authorization" did not comply with Administrative Rule 9792.9.1(a) or Administrative Rule 9792.9.1(c)(2)(B) (Cal. Code Regs., tit. 8, § 9792.9.1, subds. (a) & (c)(2)(B)), defense counsel forwarded the request for treatment to the utilization review process established by defendant pursuant to Labor Code section 4610. On September 17, 2015, defendant's utilization review

provider denied the requested treatment. The WCJ held the UR decision untimely and therefore that the WCAB had jurisdiction under Dubon to determine the issue of medical necessity.

On reconsideration, the WCAB reversed writing that "according to the utilization review determination, Dr. Valdez's request for treatment was received by the utilization review provider on September 14, 2015. Pursuant to Labor Code section 4610(g)(1) and Administrative Director Rule 9792.9.1(c)(3) (Cal. Code Regs., tit. 8, § 9792.9.1, subd. (c)(3)), defendant had five business days to issue a decision to approve, modify, delay or deny the request. The time runs from the date that a request for authorization "was received by the claims administrator or the claims administrator's utilization review organization." (Administrative Director Rule 9792.9.1(a)(1); Cal. Code Regs., tit. 8, § 9792.9.1, subd. (a)(1).) Thus, defendant's utilization review determination was due September 21, 2015. The September 17, 2015 utilization review denial was well within the time limits. Thus Time limit for UR runs from the date the request for authorization "was received by the claims administrator or the claims administrator's utilization review organization" not from date defense attorney receives request. 8 Cal. Code Reg. § 9792.9.1(a)(1). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10; Sullivan On Comp, 7.36, Independent Medical Review – Procedure; Sullivan On Comp, Section 7.34 Utilization Review – Request for Authorization.] But see conta, Czech v. Bank of America, 2016 Cal.Wrk.Comp.P.D. LEXIS 257 UR found untimely where defense attorney did nothing with request.

Favila v. Arcadia Health Care, Cypress Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 181 (Board Panel Decision)

". . . Applicant's contention that the UR and IMR reviewers relied upon outdated medical treatment guidelines and not the most recent studies that applicant claims validate the requested surgery, ignores the mandate that a mistake of fact be of a "matter of ordinary knowledge . . . and not a matter that is subject to expert opinion." The question of whether the proper medical treatment guidelines were used to determine the appropriateness of the disputed surgical treatment is clearly a matter subject to expert opinion and is not a matter of ordinary knowledge. Furthermore, Labor Code section 4610.6(i) expressly precludes the WCJ, the Appeals Board or any higher court from making "a determination of medical necessity contrary to the determination" of the IMR organization. . ."

Favila v. Arcadia Health Care, Cypress Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS at pg. 183 (Board Panel Decision)

But see, contra, McAtee v. Briggs & Pearson Construction, 2016 Cal.Wrk.Comp. P.D. LEXIS 375(BPD), ordering that new IMR determination pursuant to Labor Code § 4610.6(i) was appropriate where WCAB found that UR determination was result of plainly erroneous express or implied finding of fact as matter of ordinary knowledge based on information submitted for review where IMR reviewer erroneously applied Medical Treatment Utilization Schedule (MTUS) guideline.

See also, Gonzalez-Ornelas, v. County of Riverside, 2016 Cal. Wrk. Comp. P.D. LEXIS 151(BPD) where Applicant's IMR appeal pursuant to Labor Code § 4610.6(h)(1) and (5) granted, as IMR determination denying authorization based lack of documentation of diagnosis and failure of conservative treatment, where documentation on both existed and were provided to reviewer -- IMR determination was "plainly and directly contradicted" without need for "expert opinion" within "realm of ordinary knowledge". [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.11; Sullivan On Comp, 7.41, Independent Medical Review – Appeal and Implementation of Determinations]

Applicant appealed the UR non-certification of the PTP's RFA for artificial disk replacement surgery to IMR. The IMR upheld the UR determination. Applicant than sought review by the Appeals Board arguing that the Board should order a second IMR review because the IMR determination was based upon a plainly erroneous expressed or implied finding of fact. Applicant asserted that there is a dispute over the appropriate applicable medical guideline for determining whether the proposed surgery is reasonable, asserting that the UR and IMR physicians relied upon outdated medical information as to the efficacy of the artificial disk replacement surgery.

Labor Code section 4610.6(h) limits the grounds for an appeal from an IMR determination, which determination is "presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal: "The ground for appeal cited by applicant is set forth in section 4610.6(h)(5): The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and *not a matter that is subject to expert opinion*.

The WCAB held that a UR denial based on outdated medical treatment guidelines, is not a proper basis for IMR appeal as "plainly erroneous express or implied finding of fact" as described in Labor Code § 4610.6(h)(5) which requires that mistake of fact be matter of ordinary knowledge, not matter subject to

expert opinion, and that whether proper medical treatment guidelines were used to determine appropriateness of disputed surgical treatment is clearly matter of expert opinion and not grounds for IMR appeal. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.11; Sullivan On Comp, 7.41, Independent Medical Review – Appeal and Implementation of Determinations]

III. The Obligation to Return to the Prior/Original QME/AME.

Generally, the parties are required to return to the original report medical-legal evaluator. The medical-legal evaluator is to address all issues including injury(ies) and entitlement to benefits as of the date of the examination. However, an alternative medical-legal evaluator may be obtained as to subsequent injuries by any party. But be reminded that the parties may always agree to return to a prior QME/AME.

Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418; 2014 Cal. Wrk. Comp. LEXIS 41 (En Banc Decision)

The Applicant while employed as a police officer filed a CT claim of injury for the period ending 2/9/09. While represented by an attorney applicant was examined on 9/14/09 by a PQME. Subsequently the applicant on 10/4/10 filed additional claims alleging injuries to back occurring on 6/1/10 and 8/31/10. Defendant sought to have the applicant re-examined by the original PQME with respect to the newly filed claims of injury. Applicant objected and the parties proceeded to trial. At trial the WCJ held that the applicant was entitled to a new PQME with respect to the newly filed claims of injury, and that Rule 35.5(e) which required an employee to return to the same evaluator when a new injury or illness is claimed involving the same body parts is inconsistent with the provision of the Labor Code.

On reconsideration, the WCAB upheld the WCJ. The WCAB wrote that "the language of the statutes is mandatory, and thereby controls" and that Rule 35(e) imposes unwarranted limitations in direct conflict with Labor Code sections 4060(a), (c), and (d), 4062.1, 4062.2(a), 4062.3(j), 4062(k), 4064(a) and 4067. The WCAB further noted that where, as here, the "applicant's two claims of specific injury were reported after the original evaluation", the applicant would be entitled to a new PQME citing LC 4062.3(j) and 4064(a).

LC 4060(c) provides "If a medical evaluation is required to determine compensability at any time after the filing of the claim form, and the employee is represented by an attorney, a medical evaluation to determine compensability shall be obtained only by the procedure provided in section 4062.2…"

LC 4060(d) provides "…If a medical evaluation is required to determine compensability at any time after the claim form is filed. . .Either party may request a comprehensive medical evaluation to determine compensability. The evaluation shall be obtained only by the procedure provided in Section 4062.1."

LC 4062.2(a) provides "Whenever a comprehensive medical evaluation is required to resolve any dispute arising out of an injury or a claimed injury occurring on or after January 1, 2005, and the employee is represented by an attorney the evaluation shall be obtained only as provided in this section.

Editor's comments: Noteworthy is that 4060(a),(c) (d) and 4062.2(a) all refer to a single claim form, injury or claimed injury. Thus, where multiple injuries are pled at the same time, a party would only be entitled to a single PQME. Note also that this holding might be of use to the defense bar as well. Although this case involved the applicant wanting another bite at the PQME apple, the holding would also apply where it is the defendant seeking a new PQME on additional and subsequent claims filed by the applicant, and the original reporting PQME was pro-applicant rather than pro-defendant.

See also, Torres v. Auto Zone, 2013 Cal.Wrk. Comp. PD LEXIS 230 held electronic signature by PQME did not invalidate admissibility of med-legal report. The WCJ noted that "this (electronic signature) procedure is used by the undersigned and is not deemed contrary to workers' compensation law." See also, accord, United States Fire Insurance v. WCAB, (Love), (2007) 72 Cal Comp Cases 865.

See also, Robertson v. Bonnano 2014 Cal.Wrk.Comp. P.D. LEXIS 443 holding that failure to timely object to a treatment request on contested part of body on accepted claim pursuant to LC 4062(a) creates liability on the part of the defendant for treatment and implicitly the determination of industrial causation thereafter.

Hernandez v. Ramco Enterprises, PSI, 2016 Cal. Wrk. Comp. P.D. LEXIS 486 (BPD)

Applicant was a farm laborer who suffered multiple industrial injuries to various body parts. Applicant had previously file four claims on or before 2/9/2015 and was evaluated for those claims by panel qualified medical evaluator Ernest Miller, M.D., on 12/2/2015. Applicant file on 2/12/16 a new claim alleging injury occurring on 9/25/2015 with his employer. Applicant sought a new QME panel for the new date of injury. The WCJ found for the applicant and allowed the new Panel. Noteworthy was that the original panel was with an orthopedist and that applicant was seeking the new panel in pain specialty.

See, Portner v. Costco, Liberty Mutual Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 499 (BPD) holding dispute over appropriate qualified medical evaluator specialty must first be submitted to Medical Director as required by 8 Cal. Code Reg. § 31.5(a)(10), and 31.1(b) applicable rules do not permit parties to bypass requirement that qualified medical evaluator specialty disputes "shall be resolved" by Medical Director, and that it was improper for WCJ to issue determination without first directing parties to submit dispute to Medical Director [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[2], [4], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[2], [4], Ch. 19, § 19.37. Sullivan on Comp, Section 14.29, Medical-Legal Process]

See, Ventura v. The Cheesecake Factory, Zurich American Insurance Company, 2014 Cal. Wrk. Comp. P.D. LEXIS 417 (BPD) where Matter dropped from calendar despite no objection by Defendant to applicant's DOR as Labor Code § 4061(i), as amended by SB 863, expressly requires evaluation by agreed or qualified medical evaluator before parties can file declaration of readiness to proceed on issue of permanent disability, and no waiver by Defendant because Labor Code § 4061contains no specific time limits for objection to treating physician's permanent disability findings, and defendant acted reasonably and timely in medical legal process.); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], [2], 22.11[7], 26.03[4], 32.06[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[2], Ch. 16, § 16.54[7]. Sullivan on Comp, Section 15.17, Declaration of Readiness to Proceed]

In upholding the WCJ, the WCAB held that the applicant was allowed a new QME as the date of injury under LC 4062.3(j) and LC 4064(a) was the date the claim form was filed with the employer pursuant to LC 5401 interpreting Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418 (Appeals Board en banc opinion), despite the fact that the new claim form alleged a DOI prior to date of QME examination set on previously filed injuries, where filed subsequent to date of QME examination. The WCAB rejected defendant's suggestion that applicant had intentionally delayed filing claim for 9/25/2015 injury until after initial evaluation in order to obtain another panel qualified medical evaluator as there was no evidence to support defendant's assertion. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 22.11[11]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[11]. Sullivan on Comp, Section 14.52, Subsequent Evaluations and Additional QME Panels in Different Specialties.]

Orthopedic panel specialty was correct panel notwithstanding applicant's request for chiropractic panel; Parties' Labor Code § 4062.2, right to designate specialty is not absolute, and Medical Director has authority under 8 Cal. Code Reg. §§ 31and 31.1(b) to issue panel in different specialty if that specialty is more appropriate than specialty designated by requesting party. Garza v. O'Reilly Auto Parts, Corvel, 2017 Cal. Wrk. Comp. P.D. LEXIS 3; 82 Cal. Comp. Cases 424 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[2], [4], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[2], [4], Ch. 19, § 19.37. Sullivan on Comp, Section 14.29, Medical-Legal Process]

Applicant entitled to second QME where claimed back injury involved two cases with separate and distinct injuries with different causes, citing Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418 (Appeals Board en banc opinion). Feige v. State of California Department of Corrections, 2017 Cal. Wrk. Comp. P.D. LEXIS 10 (BPD); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.11[11], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[11], Ch. 19, § 19.37. Sullivabn on Comp, Section 14.52, Subsequent Evaluations and Additional QME]

United States Fire Insurance v. WCAB (Jose Montejo) 80 CCC 55, 2014 Cal.Wrk.Comp. LEXIS 179.

Defendant sought to provide to the PTP, the QME, and the AME the report of internist Roth M.D. obtained by defendant pursuant to LC 4064(d). LC 4064(d) allows an employer to obtain a medical

evaluation or consultation at their own expense. Although Dr. Ross did not conduct a direct examination of the applicant, he did review applicant's medical records, applicant's deposition testimony, and surveillance videotape. The report of Dr. Roth found that although treatment appropriate, the applicant was malingering and had masochistic tendencies, and may have a genetic predisposition to poor healing. Applicant objected to defendant's providing the report of Dr. Ross to the PTP, QME, or AME.

> *". . .Dr. Roth's opinions about the injured worker's compliance with post-operative treatment plans, his motivation to heal, his physical activities following the various surgical procedures, his work history before and after the work injury, and whether he is malingering, rendered without any contact with the injured worker, and with inadequate reference to the specific facts relied upon, have no probative value. . .For that reason, Dr. Roth's report should not come into evidence, either standing alone or as part of the medical record created by the panel QME or AME in this case. . ."*
>
> *United States Fire Insurance v. WCAB (Jose Montejo) 80 CCC at pg. 57*

The issue was submitted after MSC to the WJC. The WCJ sustained counsel for applicant's objection discussing at length the inadequacy of the report and finding that the report did not constitute substantial evidence. The focus was on the fact that Dr. Ross did not conduct an evaluation of the applicant but rather was limited to a forensic evaluation without reference to specific facts. Therefore was without probative value. Writ Denied.

Fernando Martinez, Applicant v. Santa Clarita Community College District, Defendant, 2015 Cal. Wrk. Comp. P.D. LEXIS 2 (BPD).

Applicant concurrently requested QME panels in the specialties of orthopedics, internal medicine, and psychiatry. At the time of the request applicant was receiving treatment for an orthopedic condition. Defendant objected arguing that applicant's request for panels in internal medicine and psychiatry was premature as applicant had failed to comply with LC 4062 and Rule 31.7. The parties proceeded trial on the issue with the WCJ finding for defendant.

Recond denied.

> *§ 31.7. Obtaining Additional QME Panel in a Different Specialty*
>
> *(a) Once an Agreed Medical Evaluator, an Agreed Panel QME, or a panel Qualified Medical Evaluator has issued a comprehensive medical-legal report in a case and a new medical dispute arises, the parties, to the extent possible, shall obtain a follow-up evaluation or a supplemental evaluation from the same evaluator.*
>
> *(b) Upon a showing of good cause that a panel of QME physicians in a different specialty is needed to assist the parties reach an expeditious and just resolution of disputed medical issues in the case, the Medical Director shall issue an additional panel of QME physicians selected at random in the specialty requested. For the purpose of this section, good cause means:*
>
> *(1) A written agreement by the parties in a represented case that there is a need for an additional comprehensive medical-legal report by an evaluator in a different specialty and the specialty that the parties have agreed upon for the additional evaluation; or*
> *(2) Where an acupuncturist has referred the parties to the Medical Unit to receive an additional panel because disability is in dispute in the matter; or*
> *(3) An order by a Workers' Compensation Administrative Law Judge for a panel of QME physicians that also either designates a party to select the specialty or states the specialty to be selected and the residential or employment-based zip code from which to randomly select evaluators; or*
> *(4) In an unrepresented case, that the parties have conferred with an Information and Assistance Officer, have explained the need for an additional QME evaluator in another specialty to address disputed issues and, as noted by the Information and Assistance Officer on the panel request form, the parties have reached agreement in the presence of and with the assistance of the Officer on the specialty requested for the additional QME panel. The parties may confer with the Information and Assistance Officer in person or by conference call.*
>
> *(c) Form 31.7 shall be used to request an additional QME panel in a different specialty.*

inevitable and bill his client not only for his time but additionally incur cost for multiple QME's within the same specialty. Applicant need only to have secured the ortho PQME and properly object to obtain an alternate specialty, or upon agree between the parties.

See also, Chanchavac v. LB Industries, Sentry (2015) 2015 Cal.Wrk.Comp. P.D. LEXIS 516.WCAB(BPD), denying removal as no irreparable harm thereby upholding defendant's right to obtain its own panel qualified medical report even though co-defendant on CT claim had already obtained panel qualified evaluator report, when applicant declined to elect carrier.

See also, Ruiz v. Schwan's Home Services (2015) 2015 Cal.Wrk.Comp. P.D. LEXIS 571 (BPD) denying removal where Psych PQME requested additional time to receive results of psychological testing, sent more detailed report dated 1/2/2015 with proof of service having same date held substantially complied with her obligations regarding reporting rejecting defendant's assertion that "bright-line" rule must be applied to reporting timeframes based on statutory language requiring qualified medical evaluator to serve initial evaluation within 30 days of examination.

See also, Salazar v. Motel 6 (2015) 2015 Cal.Wrk.Comp. P.D. LEXIS 642 (BPD) were removal denied pursuant to Matute v. Los Angeles Unified School Dist. (2015) 80 Cal. Comp. Cases 1036 (Appeals Board en banc opinion), and Razo v. Las Posas Country Club, 2014 Cal. Wrk. Comp. P.D. LEXIS 12 (Appeals Board Noteworthy Panel Decision), reasoning that Code of Civil Procedure § 1013(a) extends time period for striking name by five calendar days so that party has total of 15 days after assignment to strike name from panel qualified medical evaluator list. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[1], [6], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[1], Ch. 19, § 19.37.] See also, Adams v. Merced City School District (2015) 2015 Cal.Wrk.Comp. P.D. LEXIS 649 (BPD), 15 Days period to strike is extended where last day falls on Sunday.

IV. Is Applicant Unrepresented or Represented?

The use of an **AME** is limited to those matters where the applicant IS **REPRESENTED**, regardless of the issue. (See LC 4060(c)&(d), 4061(c)&(d), 4062(a), 4062.1(a). See also 4062.2)

Where the applicant is UNREPRESENTED, a LC 139.2 request is made for a PANEL QME.

A. In Pro Per Applicant – The Panel QME Process (LC 4062.1)

Where the **APPLICANT IS UNREPRESENTED**, a PQME must be utilized. (LC 4062.1(a)) The employee shall NOT be entitled to an additional evaluation should the applicant later become represented. (LC 4062.1(e)) A three member panel shall be provided by the medical director within 5 working days after receiving the request. If not provided within 15 working days, the employee shall have the right to obtain a medical evaluation from any QME of his or her choice. The unrepresented applicant shall select the specialty. (LC 139.2 (h)(1)) The PQME is required to prepare and submit the report within 30 days of the evaluation. (LC 139.2(j)(1)(A))

Errors by Employee: LC 4062.1 (b) & (c)

(1) Failure to submit PQME request within 10 days of employer providing form and request that employee submit – Employer may then submit and DESIGNATE SPECIALTY.

(2) Within 10 days of issuance of the PQME, the employee shall select, schedule the appointment, and inform the employer of the selection and appointment. Failure to do so will allow employer to select the physician from the panel. The employer is responsible for scheduling the appointment where either the employee has (1) informed the employer of the selection but failed to schedule the appointment within 10 days of issuance of the PQME or (2) fails to make selection.

B. Represented Applicant (LC 4062.2)

Where the applicant is REPRESENTED, the procedures pursuant to LC 4062.2 are to be utilized. They require that where any issue arises under Labor Codes 4060 (AOE/COE), 4061 (PD) or 4062 (Catch All Provision) the parties shall first send written offer of AME. An agreement for AME may be sought for a period of 10 days, extended by agreement between the parties an additional 20 days. Thereafter either party may request PQME.

(1) The party "submitting the request shall designate the specialty of the medical evaluator". (4062.2(b)) But shall also disclose the specialty of the treater, and opposition's specialty

preference if know. The party submitting the request shall also serve a copy of the PQME request on the other party.

(2) Within 10 days of "assignment of the panel", the parties shall confer and attempt to agree upon an Agreed PQME. Where the parties fail to agree by the 10th day, each party shall have 3 days within which to strike one doctor from the panel. The remaining physician shall serve as the PQME. WHERE ONE PARTY FAILS TO EXERCISE THE RIGHT TO STRIKE, THE OTHER PARTY MAY SELECT THE PHYSICIAN. (4062.2(c))

(3) The represented employee shall have 10 days to arrange the PQME examination, and upon failure to do so the employer shall made the appointment.

(4) The employee who later ceases to be represented is not entitled further PQME (4062.2(e))

Messele v. Pitco Foods, California Insurance Company (2011) 76 CCC 1187 (En Banc Decision)

Applicant sustained a specific injury occurring on 1/29/10 to hands and other body parts. On 4/20/10 defendant sent written objection to the PTP opinion, and proposing an AME pursuant to LC 4062. This objection was sent by mail. Six days later Counsel for Applicant offered by fax several different physicians to serve as AME. On 5/1/10, eleven days after Defendant's objection, Counsel for Applicant submitted to the DWC Medical Unit a request for a pain medicine panel. The Applicant's request noted that the PTP was a hand specialist and that the defendant's preference was therefore a hand specialist. On 5/4/10, fourteen days after Defendant's original objection, Defendant sent a request seeking an orthopedic hand specialist. On 5/5/10, fifteen days after Defendant's objection letter the DWC Medical Unity received Applicant's request, and issued a pain medicine panel. On 5/10/10 the Medical Unit received the Defendant's request and issued a second panel of three hand specialists. On 10/6/10 the applicant was evaluated by pain management physician from the first panel. Trial was held on12/29/10 on the sole issue of which panel was proper.

4062(a) provides ". . .if an injured employee is represented by an attorney the parties have 20 days to object to a medical determination by the treating physician. . ."

4062(b) provides ". . .if either party requests a medical evaluation pursuant to Section 4060, 4061, or 4062, either party may commence the selection process for an agreed medical evaluator by make a written request naming at least one proposed physician to be the evaluator. The parties shall seek agreement with the other party on the physician. . .If no agreement is reached within 10 days of the first written proposal that names a proposed agreed medical evaluator. . .either party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation. The party submitting the request shall designate the specialty of the medical evaluator, the specialty of the medical evaluator request by the other party if it has been made known to the party submitting the request, and the specialty of the treating physician. . ."

LC. 4062.2 requires the requesting party to designate the specialty, the specialty of the PTP and if known the preference of the other party.

Editor's Comments: First, note that CCP 1013 (c) governs express mail, (e) governs facsimile transmission, and (g) electronic service, all of which provide an extension of two court days. Second, this Editor would analyze this case slightly different noting that CCP 1013(a) is generally applicable whenever service by mail with two exceptions: when service of a document is NOT the operative trigger for the time period, and when a jurisdictional deadline is involved. (See Camper v. WCAB 1992, 57 CCC 644 where writ of review period was filing of the WCAB decision not service of a document and LC 5950 was held to be a jurisdictional deadline.) (Recall also that 1013(a) 5 day extension was held not to apply to the time period for striking a doctor from a QME panel as the operative trigger was the striking of the name from the list not service of a document. See Alvarado v. WCAB (2007) 72 CCC 1142).

By separate decision on 11/22/11, the WCAB held that Messele applied prospectively to requests made on or after 9/26/11.

The WCJ held that CCP 1013(a) applied to extend by five calendar days the 10 days within which to agree on an AME, and that the first day on which either party could request a panel was therefore on the 5/6/10, which was 16 days after defendant's objection letter. The WCJ initially held that the defendant's panel was the proper panel, but in his Report and Recommendation, the WCJ reversed himself recommending that reconsideration be granted, and that both panel be found to have been prematurely requested.

By En Banc decision the WCAB held that CCP 1013(a) applied to LC 4062(b) to extend by five days the right to request a panel. The WCAB noted that written objection to a medical determination of the PTP is the triggering event. Thereafter the parties have 10 days to discuss the use of an AME. Further, that where the

written request is sent by mail this period is extended by 5 days by CCP 1013(a). The Court's analysis relied on the critical fact that service of the objection was requested to be in writing and where sent by mail this results in the first date upon which the panel can be requested is the 16th day after the objection to the PTP medical treatment determination.

V. What Is the Issue?

A. AOE/COE -- LC 4060

LC 4060 shall ONLY apply where **ALL PARTS OF BODY** with regard to any injuries are **DISPUTED/CONTESTED.** Where applicant is **REPRESENTED THEN LC 4062.2** procedures. If **UNREPRESENTED**, then LC 4062.1

Editor's Comments: Please note the Rule 30(d) prohibiting the employer from requesting and securing a 4060 AOE/COE report after denial of claim was struck down by the decision of Mendoza v. WCAB (2010) 75 CCC 1204 (En Banc Decision); Amelia Mendoza v. Huntington Hospital, PSI, Sedgwick Claim Management Services, (2010) 75 CCC 634. (En Banc.)

B. Permanent Disability – LC 4061

Together with the last payment of TD, employer shall provide notice of NO PD, PD or too early to determine as employee is not yet P&S. This notice must **INCLUDE THE PROCEDURES SHOULD THE EMPLOYEE DISAGREE** with the employer's decision. Where the employer determines that PD is owed, the notice must state the basis, percentage and amount, and the employer shall commence payments or promptly commence proceeding before the appeals board to resolve the issue.

4061 notices require the following language: "should you decide to be represented by an attorney, you may or may not receive a lager award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits." (LC 4061(b))

". . .With the exception of an evaluation . . .prepared by a treating physician, no evaluation of permanent impairment shall be obtained, except in accordance with Section 4062.1 and 4062.2. Evaluation obtained in violation of this prohibition shall not be admissible in any proceeding before the appeal board." (LC 4061(i))

Where the parties fail to agree on PD, either party may request PQME. Where applicant is represented LC 4062.2 procedures apply, if unrepresented LC 4062.2 procedures apply.

C. Issues NOT Including AOE/COE, PD or Medical Treatment/4610 – LC 4062

LC 4062 is the "CATCH ALL" PROVISION, generally applying to TD/P&S determinations.

Anytime either party objects to a medical determination made by the treating physician not involving AOE/COE (4060), PD (4061) OR MEDICAL TEATMENT/UR(4610), the objecting party has 20 days if employee is represented, 30 days if employee is unrepresented from date of receipt of report to notify the other party of the objection in writing. (LC 4062(a))

Labor Code 4062(a) provides ". . .Employer objections to the treating physician's recommendations for spinal surgery shall be subject to [4062(b)], and after denial of the physician's recommendations, in accordance with Section 4610. If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of the decision. These time limits may be extended for good cause or by mutual agreement."

If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a request for authorization of a medical treatment recommendation made by a treating physician, the objection shall be resolved only in accordance with the independent medical review process established in Section 4610.5.

If the employee objects to the diagnosis or recommendation for medical treatment by a physician within the employer's medical provider network established pursuant to Section 4616, the objection shall be resolved only in accordance with the independent medical review process established in Sections 4616.3 and 4616.4.

J.C. Penny v. WCAB (Edwards) (2009, 3rd District Court of Appeal)175 Cal.App. 4th 818, 37 CWCR 141, 74 CCC 826.

Applicant sustained injury to back and knee which resulted in knee surgery in February 2005 and later a referral to a spinal surgeon who recommended surgery in October 2006. Defendant through the UR process denied the surgery. The UR denial was supported by Dr. Anderson who provided a second surgical opinion and report dated 2/14/06. The applicant's PTP however continued to report the applicant as TD through 2006 and in need of surgery. The parties selected Dr. Peter Mandell to act as the AME. Dr. Mandell in his report of 2/5/07 declared the applicant P&S as of 6 months post knee surgery or 8/05. Defendant however, had provided TD until 3/14/07, a date shortly after receipt of the report. The matter proceeded to trial with defendant asserting a credit for TD overpayment during the period from 8/05 through 3/14/07.

> *"The requirement for an objection under section 4062 is stated in mandatory language: 'the objecting party shall notify the other party in writing.' The ordinary meaning of a mandatory time limit is that once the prescribed time has passed the action subject to the time limit may no longer be taken. When JC Penny failed to object to a medical determination of TTD by Edwards's treating physician within the time limit provided in section 4062, it lost the right to object to that determination in the future.*
>
> *The evident purpose of the time limits in section 4062 is to induce both employer and employee to declare promptly medical determination disputes and expeditiously resolve them through the prescribed mechanisms. This purpose cannot be attained if a party. . .can fail to object in a timely manner and nonetheless thereafter tender a claim that contradicts a medical determination subject to the object requirement of the statute. If either employer or employee fails to raise a dispute about a medical determination within the ambit of section 4062 within the prescribed time, they may not attack that determination thereafter.. ."*
>
> *J.C. Penny v. WCAB (Edwards) 74 CCC at pgs. 831-832.*

The WCJ denied defendant's credit before the date of the AME exam finding the applicant to have become P&S as of the date of the AME examination (2/5/07). The WCJ held that the reports of the PTP supported a finding of continuing TD and that defendant's failure to timely object resulted in a waiver of any right to assert applicant was P&S prior to the report of the AME. The WCJ wrote that it would "violate the spirit of LC 4062" for defendant to have not objected and yet be allowed to assert a retroactive P&S date for the purpose of claiming a credit. Reconsideration was denied.

On Writ of Review the 3rd District Court granted defendant's request and requested that the parties address the issue raised by the WCJ as to the "spirit of LC 4062". Defendant argued that the reports of the PTP relied upon did not constitute substantial evidence in that it was predicated upon the need for surgery which was not indicated. The Court spent little time addressing the substantial evidence argument of defendant deciding the issue based upon an analysis of LC 4062. The Court noted that the language of LC 4062 acted as a bar to recovery of overpayment, not that there was no TD overpayment. The Court held that objection under 4062 was mandatory, and failure of defendant to object timely results in the loss of the right to object and attack that determination in the future. Thus, the Court held that failure by the defendant to timely object to the physician's report will bar defendant's right to later contest the issue and claim credit for any TD overpayment determined to have occurred. Therefore, the analysis is not whether substantial evidence existed to refute the claim of TD, but rather simply whether defendant timely objected to the PTP opinion. In this case defendant failed to do so.

Christensen v. Zurich Amer. Ins. Co. (November 2014) 42 CWCR 249 (orders dismissing petition for reconsideration and granting removal; decision after removal).

Applicant sustained injury on 1/29/09 to right knee, back and left knee as a compensable consequence. The intial course of treatment focused on the right knee, although the medical reports continued to document pain in the left knee. At deposition the PTP testified that he did not have a diagnosis for the left knee and that an MRI "might be necessary". Ultimately an MRI was performed which lead to a RFA to surgery. When defendant refused to take action the applicant filed for expedited hearing. At hearing the WCJ vacated the submission and ordered further development of the record.

Applicant sought removal on the grounds that (1) the defendant had not timely objected to the PTP reports; (2) the proper result of such a failure to object should be to authorize the surgery; (3) it was inconsistent for the defendant to both deny liability on the left knee and submit the request for surgery to UR.

The WCAB first determined that removal was appropriate as "irreparable harm" would result from further delay. Next the majority noted that although the UR physician report is relevant to the IMR process it is not admissible on the issue of injury including part of body. On the issue of part of body the WCAB noted that the early reports of the PTP both explicitly and impliedly found the left knee condition to be related to the industrial injury. Further it was listed as a part of body on the Application for Adjudication of Claim. Here the defendant had a duty under § 4062 to object to the report of the PTP within 20 days if they were contesting liability for treatment on the left knee. Here however, since the defendant failed to object to various treating physician report or even the RFA, but merely submitted the RFA to UR which approved the surgery request, surgery must be authorized.

Labor Code § 4062. Objection to medical determination by treating physician; Notice; Medical evaluation

(a) If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section 4062.2, and no other medical evaluation shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in Section 4062.1, and no other medical evaluation shall be obtained.

Editor's Comments: See also, accord, Simmons v. Department of Mental Health (2005) 35 CWCR 162, 70 CCC 866 holding the defendant must timely object to the compensability of a body part if it disputes industrial causation and institute proceedings under LC 4062, the AME/QME process. The issue of causation is not an appropriate issue for a UR physician to determine. Also recall the past decision of J.C. Penny v. WCAB (Edwards) (2009, 3rd Appellate District) 175 Cal.App.4th 818, 37 CWCR 141, 74 CCC 826 which held that the although the defendant was entitled to a credit for TD overpayment when AME rectro-actively determined applicant to be P&S, defendant was precluded from asserting that credit against PD due to defendant's failure to specifically object to treaters opinion on whether applicant continued to be TD, as required by LC 4062. (Accord, Jones v. Tulare District Hospital 2014 Cal.Wrk.Comp.P.D. LEXIS 593)

D. Utilization Review/Independent Medical Review – LC 4610, et seq.

See UR/IMR Procedures Outline.

VI. AD RULES 30 – 38

Rule 30

(1) Rule 30(a) & (b)

The PQME request in the unrepresented cases made pursuant to LC 4062.1 shall be made pursuant to Form 105 with the claim examiner/employer providing the form along with Attachment "How to Request a PQME if you do Not have an Attorney" to the unrepresented applicant.

Editor's Comments: Please note the Rule 30(d)(1)&(2) prohibiting the employer from requesting and securing a PQME 4060 AOE/COE panel and therefore report after denial of claim was struck down by the recent decision of Mendoza v. WCAB (2010) 75 CCC 1204 (Panel Decision)

But note that the Court in Mendoza did not address whether Rule 30(d)(3) which prohibits a PQME 4060 AOE/COE panel requested after the 90 days without an order of the WCJ is proper.

The PQME request in the represented cases made pursuant to LC 4062.2 shall be made pursuant to Form 106 with the requesting party (1) Identifying the dispute, (2) Attaching a copy the proposed AME attempt between the parties, (3) Designate the specialty, (4) and state the specialty of the PTP.

Rule 31(c)

Any physician who has provided treatment for the disputed injury pursuant to 9785 is PROHIBITED from acting as the PQME.

Rule 31.1 – Represented Cases

Where multiple requests for PQME's pursuant to LC 4062.2 (Represented Applicant) are received by the Medical Director ON THE SAME DAY and the requests DESIGNATE DIFFERENT SPECIALTIES, the Medical Director shall:

(1) Where requested, select the specialty consistent with that of the treater, UNLESS the Medical Director is PERSUADED by supporting documentation provided by the requestor.

(2) Where no party selects the specialty of the treater, then the Medical Director shall select the a specialty APPROPRIATE for the disputed medical issue.

(3) Further, upon request by the Medical Director, the party requesting the panel shall provide medical records to assist the Medical Director in determining the appropriate specialty.

(4) Supporting documentation appears to be required where the requesting party seeks a specialty different than that of the treater. *(31.1(3))*

Rule 31.3 - Scheduling Appointment

The UNREPRESENTED APPLICANT shall have **10 DAYS** of receipt of the PQME to SELECT AND SCHEDULE the PQME examination. The employer representative is PROHIBITED from DISCUSSING THE SELECTION of the PQME with the unrepresented applicant. Where the REPRESENTED or UNREPRESENTED APPLICANT fails to schedule the medical examination within 10 days of the receipt of the PQME, the employer/defendant shall schedule the examination. Recall also that where the unrepresented applicant fails to select the PQME within 10 days of receipt of the PQME, then the employer shall make the selection. *(See LC 4062.1(c))*

Rule 31.5 – QME Replacement Requests

Replacement Doctor to the PQME or a entirely NEW Panel shall be randomly selected by the Medical Director where (1) specialty of the panel or an individual doctor on the panel does not practice in the requested specialty; (2) the selected PQME cannot set the appointment within 60 days of the initial request by the scheduling party; (3) applicant has changed residence prior to the initial evaluation; (4) PQME is unavailable pursuant to Rule 33; (4) QME on the panel is or has been a treater; (5) for the convenience of the applicant only, and upon written agreement with the employer/defendant; or (6) for "good cause" limited to documented medical or psychological impairment; (7) The specialty selected is medically or otherwise INAPPROPRIATE for the disputed medical issue; (8) Violation of Rule 34, Appointment Notification and Cancellation; (9) Violation of timelines pursuant to LC 4062.5 and Rule 38 (completion of timely evaluation – 30 days of evaluation, supplemental report 60 days of request)

Rule 31.7 – Additional QME Panel in Different Specialty

"Upon a showing of good cause that a different specialty" PQME is appropriate, the Medical Director shall issue additional panel. *"Good Cause"* exists (1) by order of the WCJ *(see also AD Rule 32.6)*; (2) QME notifies the parties and the Medical Director that they cannot comply with the time lines; (3) in a REPRESENTED CASE written agreement between the parties that additional specialty is appropriate and the parties are unable to agree to an AME; (4) In an UNREPRESENTED CASE, with the assistance of the Information and Assistance Officer have reached agreement in the presence of the I&O Officer.

Rule 33 – Unavailability of QME

QME appointment must be scheduled within 60 days of the request by the party with the legal right to schedule the appointment, or 90 days if the requesting party agrees to waive the right to a replacement panel. *(Rule 33(e))*

Editor's Comments: Please note the Rule 31.3 & 4062.1(c) create a situation where if (1) the unrepresented worker fails to select or (2) select but fails to schedule the PQME within 10 days of receipt of the panel, then it is the employer who shall schedule the PQME exam and who may request an alternate PQME panel where the selected PQME cannot conduct the exam within 60 days of the employer's request for examination.

VII. Recent Case Law Development

Hernandez v. Ramco Enterprises, PSI, 2016 Cal. Wrk. Comp. P.D. LEXIS 486 (BPD)

Applicant was a farm laborer who suffered multiple industrial injuries to various body parts. Applicant had filed previously four claims on or before 2/9/2015 and was evaluated for those claims by panel qualified medical evaluator Ernest Miller, M.D., on 12/2/2015. Applicant file with his employer on 2/12/16, after his QME examination, a new claim alleging injury occurring on 9/25/2015, prior to the QME examination date.

See, Portner v. Costco, Liberty Mutual Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 499 (BPD) holding dispute over appropriate qualified medical evaluator specialty must first be submitted to Medical Director as required by 8 Cal. Code Reg. § 31.5(a)(10), and 31.1(b) applicable rules do not permit parties to bypass requirement that qualified medical evaluator specialty disputes "shall be resolved" by Medical Director, and that it was improper for WCJ to issue determination without first directing parties to submit dispute to Medical Director [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[2], [4], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[2], [4], Ch. 19, § 19.37. Sullivan on Comp, Section 14.29, Medical-Legal Process]

See, Garza v. O'Reilly Auto Parts, Corvel, 2017 Cal. Wrk. Comp. P.D. LEXIS 3; 82 Cal. Comp. Cases 424 (BPD) deciding orthopedic panel specialty was correct panel notwithstanding applicant's request for chiropractic panel; Parties' Labor Code § 4062.2, right to designate specialty is not absolute, and Medical Director has authority under 8 Cal. Code Reg. §§ 31and 31.1(b) to issue panel in different specialty if that specialty is more appropriate than specialty designated by requesting party. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[2], [4], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[2], [4], Ch. 19, § 19.37. Sullivan on Comp, Section 14.29, Medical-Legal Process]

See, Feige v. State of California Department of Corrections, 2017 Cal. Wrk. Comp. P.D. LEXIS 10 (BPD), holding applicant entitled to second QME where claimed back injury involved two cases with separate and distinct injuries with different causes, citing Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418 (Appeals Board En Banc opinion); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.11[11], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[11], Ch. 19, § 19.37. Sullivabn on Comp, Section 14.52, Subsequent Evaluations and Additional QME]

Applicant sought a new QME panel for the new date of injury. The WCJ found for the applicant and allowed the new Panel. Noteworthy was that the original panel was with an orthopedist and that applicant was seeking the new panel in pain specialty.

In upholding the WCJ, the WCAB held that the applicant was allowed a new QME as the date of injury under LC 4062.3(j) and LC 4064(a) is the date the claim form was filed with the employer pursuant to LC 5401 interpreting Navarro v. City of Montebello (2014) 79 Cal. Comp. Cases 418 (Appeals Board en banc opinion), despite the fact that the new claim form alleged a DOI prior to date of QME examination set on previously filed injuries, but was filed subsequent to date of QME examination. The WCAB rejected defendant's suggestion that applicant had intentionally delayed filing claim for 9/25/2015 injury until after initial evaluation in order to obtain another panel qualified medical evaluator as there was no evidence to support defendant's assertion. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 22.11[11]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[11]. Sullivan on Comp, Section 14.52, Subsequent Evaluations and Additional QME Panels in Different Specialties.]

See, Ventura v. The Cheesecake Factory, Zurich American Insurance Company, 2014 Cal. Wrk. Comp. P.D. LEXIS 417 (BPD) where matter dropped from calendar despite no objection by Defendant to applicant's DOR as Labor Code § 4061(i), as amended by SB 863, expressly requires evaluation by agreed or qualified medical evaluator before parties can file declaration of readiness to proceed on issue of permanent disability, and no waiver by Defendant because Labor Code § 4061contains no specific time limits for objection to treating physician's permanent disability findings, and defendant acted reasonably and timely in medical legal process.); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], [2], 22.11[7], 26.03[4], 32.06[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[2], Ch. 16, § 16.54[7]. Sullivan on Comp, Section 15.17, Declaration of Readiness to Proceed]

See also, Luisa Lopez v. County of San Joaquin, PSI, administered by Tristar Risk Management2017 Cal. Wrk. Comp. P.D. LEXIS 197, held that applicant entitled to QME/AME re-examination on petition to reopen pursuant Labor Code § 4062.3(k), as the report after re-examination is admissible on existence, prior to end of five-year period, of new and further disability. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.06[1][e], 32.06[1][f]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[4][f]. Sullivan on Comp, Section 14.52, Subsequent Evaluation and Additional Qualified Medical Evaluator Panels in Different Specialties]

See also, Yarbrough v. Southern Glazer's Wine and Spirits, 2017 Cal. Wrk. Comp. P.D. LEXIS 508 (BPD), holding Labor Code § 4062.2(f) only precludes withdrawal from agreed medical examiner after agreed medical examiner has conducted evaluation, but does not preclude unilateral withdrawal by party before submitting to evaluation. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1][a], 22.11[11], 26.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03[1], [2], Ch. 16, § 16.54[11], Ch. 19, § 19.37. Sullivan on Comp, Section 14.29, Medical-Legal Process – Represented Employee]

See also, Dorantes v, Dirito Brouthers and Insurance Co. of the West, 2017 Cal. Wrk. Comp. P.D. LEXIS 237 (BPD), holding that although 8 Cal. Code Reg. §38(i) creates guidelines for the timeline for supplemental QME report, the 60 day requirement when read with Labor Code §4062.5 does not mandate replacement QME Panel absent good cause such as that the delay would result in prejudice to the parties, and the issue of whether the QME report was substantial evidence was not grounds for replacement under 8 Cal. Code Reg. §31.5. See also, Garcia v. Child Development, Inc. 2017 Cal.Wrk.Comp.P.D. Lexis 112, Alvarado v. CR&R Inc, 2016 Cal.Wrk.Comp.P.D. LEXIS 112, Corrando v. Aquafine Corp. 2016 Cal.Wrk.Comp.P.D. LEXIS 318 [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 22.11[4], [6], 22.13; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.54[6], [14].]

Catin v. J.C. Penney, Inc., American Home Assurance, 2017 Cal. Wrk. Comp. P.D. LEXIS 106 (BPD)

Applicant sustained injury which was ultimately resolved via C&R with open med. An issue arose over medical treatment with defendant seeking to return the applicant for re-examination to the AME pursuant to LC 4050. The WCJ agreed by minute order.

On removal, the WCAB held that Applicant may not be compelled to attend 4050 consultation re-examination with AME post C&R with open med, as the original purpose of Labor Code § 4050 was subsumed by more specific statutes, including Labor Code §§ 4060, 4061, 4062, and 4610. Labor Code § 4050 cannot circumvent process set forth in these provisions, in the absence of additional issues beyond medical treatment justifying further examination pursuant to including Labor Code §§ 4060, 4061, 4062. The Court provided an excellent discussion and analysis citing Nunez v. Workers ' Comp. Appeals Bd., 136 Cal.App.4th 584

Editor's Comments: While the holding in Batten puts to rest securing a privately retained medical-legal report not secured pursuant to Labor Code Sections 4060, 4061, 4062, 4062.1 4062.2 for the purpose of establishing injury and entitlement to PD, Catin also puts to rest securing a medical report" for purposes of addressing issues involving medical treatment.

See also, Cortez v. WCAB (2006) 136 Cal.App.4th 596, 71 CCC 155 in which attempts to secure medical-legal opinions under LC sections 4050 and/or 5701 where both held improper and therefore inadmissible on a pre-SB-899 med-legal case and that the only way in which to obtain an admissible med-legal report is pursuant to LC 4062 et. seq.

See also, Ward v. City of Desert Hot Springs (2006) 34 CWCR 266, 71 CCC 1313 (WCAB Significant Panel Decision) where the WCAB upheld the WCJ noting the limiting language contained in LC 4060(c) and 4062.2(a) which provides that medical evaluations "shall be obtained only" by the procedures contained in 4060& 4062.2 without mention of 4064. The WCAB noted the conflict was irreconcilable and therefore the new amended sections must prevail over the older section of 4064. See also, accord, Nunez v. WCAB (Assoluto, Inc) 136 Cal.App. 584; 38 Cal.Rptr. 3d 914; 71 CCC 161; 2006 Cal.App. LEXIS 157.

[71 Cal.Comp.Cases 161]; Cortez v. Workers' Compensation Appeals Bd., 136 Cal.App.4th 596 [71 Cal.Comp.Cases 155]; Batten v. Workers' Comp. Appeals Bd. (2015) 241 Cal.App.4th 1009, 1015. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 22.06[1], 22.07[2][a], 22.11[11], 24.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.03, Ch. 16, § 16.54[11], Ch. 19, § 19.37.]

THE
UTILIZATION REVIEW
AND
INDEPENDENT MEDICAL REVIEW (IMR)
Process

The following represents a summary and analysis of some of the most recent case decisions issued by the California Supreme Court, California Court of Appeal, and the Workers' Compensation Appeals Board, and Statutes which the Editor believes is significant to the UR/IMR process, as well as the practice of Workers' Compensation law generally. The summaries are only the Editor's interpretation, analysis, and legal opinion, and the reader is encouraged to review the original case decision in its entirety.

Practitioners should proceed with caution when citing to this panel decision and should also verify the subsequent history of the decision. WCAB panel decisions are citeable authority, particularly on issues of contemporaneous administrative construction of statutory language [see Griffith v. WCAB (1989) 209 Cal. App. 3d 1260, 1264, fn. 2, 54 Cal. Comp. Cases 145]. However, WCAB panel decisions are not binding precedent, as are en banc decisions, on all other Appeals Board panels and workers' compensation judges [see Gee v. Workers' Comp. Appeals Bd. (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cases 236]. While WCAB panel decisions are not binding, the WCAB will consider these decisions to the extent that it finds their reasoning persuasive [see Guitron v. Santa Fe Extruders (2011) 76 Cal. Comp. Cases 228, fn. 7 (Appeals Board En Banc Opinion)]. Panel Decisions which are designated as "Significant" by the WCAB, while not binding in workers compensation proceedings, are intended to augment the body of binding appellate court and en banc decision and is limited to panel decisions involving (1) issue(s) of general interest to the workers' compensation community, especially a new or recurring issue about which there is little or no published case law; and (2) upon agreement en banc of all commissioners on the significance and importance of the issues presented and resulting decisions. (See Elliot v. WCAB (2010) 182 Cal.App. 4th 355, 361, fn. 3, 75 CCC 81; Larch v. WCAB (1999) 64 CCC 1098, 1099-1100 (writ denied).

Due to the complexities, this author has decided to address IMR by an organized summary of relevant sections of the Labor Code, and Title 8 Regulations under Three headings: (1) Time Periods and Procedures for UR-IMR; (2) Time Periods and Procedures for MPN-IMR; and (3) Appeal of IMR Determination;

I. Overview of UR-IMR and MPN-IMR Process

A. Effective Date:

Effective for all DOI occurring after 1/1/13 and all DOI after 7/1/13 the legislature, as part of SB 863, has directed that all medical treatment issues are to first be submitted to Utilization Review, or follow Medical Provided Network treatment procedures, with all medical treatment issues involving denial/disputes over care/treatment to be appealed by the applicant through the Independent Medical Review process and procedures. *Lab. Code §§4610.5(a)(1) & (2)*; See generally *Lab. Code §§4610, 4610.1, 4610.5, 4610.6, 4616.3, 4616.4; UR/IMR Emergency Regulations, Cal. Code Regs., tit. 8, §§ 9792.9, 9792.9.1, 9792.10.3, 9792.10.4, 9792.10.5, 9792.10.6, 9792.10.7*

One distinction between UR-IMR procedures and MPN-IMR procedures should be highlighted. Under UR-IMR, it is the employee seeking authorization of the treater's recommended course of treatment after the employer has denied the care following a UR

denial/non-certification. However, under MPN-IMR, it will be the applicant who is disputing the recommendations of the treater and, after securing a 2nd and 3rd opinion, goes forward to request IMR. *(Lab. Code 4616.3(c); Lab. Code 4616.4(b).*

II. The UR Process

A. Time Periods and Procedures for UR

Basic Timeline for UR: Prospective/Concurrent Decisions on requests for authorization of treatment made within **5 days from receipt of information "reasonably necessary"** to make the determination, **but in no event more than 14 days from treatment recommendations.** *Lab. Code §4610(g)(1); Cal. Code Regs., tit. 8, §9792.9.1.* Decision to approve, modify, delay or deny must generally be **communicated within 24 hours** to the requesting physician. *Lab. Code §4610(g)(3)(a).*

a. Check List for Defects In UR Denial

1. Was UR Denial Valid?: Timely (5-14 days) *Lab. Code 4610(g);*
2. UR physician must be competent to evaluate medical necessity? *Lab. Code 4610(e); Cal. Code Regs., tit. 8, §9792.9(g)*;
3. UR denial must be communicated to proper parties? *Lab. Code 4610(g)(2) & (g)(3)(A);*
4. Did the UR denial include DWC Form IMR with instruction to applicant? *Cal. Code Regs., tit. 8, §9792.9.1(e)(5)*

b. Remedies For Defective UR Denial

Editor's Comments: Please note that two cases working their way up to the Supreme Court filed by the applicants' bar attacking the IMR process primarily on due process/constitutional grounds. These cases are Zuniga v. WCAB (Interactive Truck, SCIF) ADJ2563341(1st Appellate District) filed by Lisa Ivancich; and Stevens v. Outspoken Enterprise and SCIF (September 2014) 42 CWCR 194 (Order Denying Reconsideration (ADJ1526353) filed by Joseph Waxman. Among the arguments asserted were that the restricted grounds of review ran afoul of the constitutional mandate that all determinations within the workers' compensation system be subject to judicial review, that the nature of the review process is so restrictive as to deny injured workers basic due process rights, and that the scheme is contrary to the separation of powers clause of Article III.

Both were denied holding the UR/IMR procedure constitutional under the California Supreme Court.

Dubon v. World Restoration Inc., SCIF (2014) 79 CCC 1298, 79 CCC 566, 79 CCC 313, 42 CWCR 219 (En Banc Decision)

The applicant sustained successive injuries in 2003 and 2004 to various parts of body. The applicant underwent a course of treatment which included various diagnostic studies including EMG/NCV (positive for L4-5 radiculopathy), Lumbar MRI (positive for L4-5 disc protrusion) and a discogram (positive for L4-5 and L5-S1 discogenic pain). The PTP referred the applicant to Dr. Simpkins for evaluation regarding further treatment including the need for surgery. On July 1, 2013 Dr. Simpkins requested authorization for surgery. Defendant submitted the request for UR and thereafter the defendant's UR agent sent a denial letter to Dr. Simpkins. The evidence relied upon by the UR physician did not contain any report from the applicant PTP, only one report from the treating/evaluation surgeon Dr. Simpkins, no reports from the AME who had requested the discogram, nor the discogram report. The UR physician apparently was provided with 18 additional pages of medical records which were not specifically commented upon. The basis for the UR denial was the lack of documented imaging of nerve root compression; no evidence that conservative treatment had failed; and no documented condition/diagnosis for which spinal fusion was indicated. The WCJ found for the defendant holding that despite the procedural defects with defendant's UR described as "critical errors" any alleged procedural defects must be resolved through IMR, as the need for surgery involved an issue of medical necessity.

On reconsideration, the WCAB reversed the WCJ. The WCAB first confirmed that "IMR solely resolves disputes over the medical necessity of treatment requests" where the UR is not invalid. However, issues of timeliness and compliance with statutes and regulations governing UR are legal disputes within the jurisdiction of the WCAB. Second, the WCAB held "a UR decision is invalid if it is untimely or suffers from material procedural defects that undermine the integrity of the UR decision. Minor technical or immaterial defects are insufficient to invalidate a defendant's UR determination, rather a UR decision is invalid only if it suffers from material procedural defects that undermines the integrity of the UR

Editor's Comments: While Dubon I placed the burden on the defendant/claims adjuster to submit to the UR physician all relevant information necessary for UR physician to address the issue of medical necessity, Dubon II clearly places the burden on the applicant/applicant attorney to ensure timely submission by defendant, as well as that the defendant has submitted all relevant documentation/information to the UR physician and limits to review through the IMR process on the issue of medical necessity, absent an untimely UR submission by defendant.

But see, the dissenting opinion by Commissioner Sweeney who relying on the California Supreme Court decision of Sandhagen wrote "A treatment determination that does not comply with section 4610 is not a 'decision pursuant to section 4610,' and thus by definition is not a 'utilization review decision.' A utilization review decision is a necessary prerequisite for independent medical review, and by the terms of sections 4610 and 4610.5, only a dispute after a utilization review decision, i.e., a treatment determination that complies with section 4610, is resolved through independent medical review. Therefore, a dispute over a treatment determination without compliance with section 4610 is not a dispute over a utilization review decision pursuant to section 4610.5(a), and such is dispute is not subject to section 4610.5 independent medical review." Further, judicial review and decision based on substantial medical opinions is not contrary to the legislative intent behind the IMR process that medical necessity be determine by medical professionals rather than the judiciary. Succinctly, Commissioner Sweeney concluded her opinion writing "Section 4610 established a utilization review process with mandatory requirements. Section 4610.5 established a process of independent medical review of a utilization review decisions. Treatment determinations that do not comply with section 4610 are not utilization review decisions and are not subject to independent medical review, controversies as to those determinations must be resolved by the WCAB pursuant to section 4604."

This editor is unaware of any Reg or Labor Code section which limits evidence/information which is provided to the IMR physician to that available at the time the UR process was begun. The applicant therefore might to able to obtain/generate evidence after review of the UR determination to be used as rebuttal on IMR.

See also, accord, infra, Bodam v. San Bernardino County/Department of Social Services (2014) 79 CCC 1519, 2014 Cal.Wrk.Comp.LEXIS 156 (Significant Panel Decision) which held that a defendant is obligated to comply with all time requirements in conducting UR, including the timeframes for communicating the UR decision; (2) A UR decision that is timely made but is not timely communicated is untimely; (3) when a UR decision is untimely and therefore invalid, the necessity of the medical treatment at issue may be determined by the WCAB based upon substantial evidence. LC 4610(g)(1)-(3) requires that the decision be communicated within 24 hours for concurrent review and 2 days for prospective review. (Accord, Vigil v. Milan's Smoke Meats (SCIF) 2014 Cal.Wrk.Comp. LEXIS __)

See also, Stock v. Camarillo State Hospital, SCIF (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 471 (Board Panel Decision) (ADJ2426407/Oxnard) involving the request for a hospital bed for applicant with two level lumbar fusion who could not sleep in flat bed and had been sleeping in recliner for past four years. The WCAB upheld WCJ's determination that RFA from MPN doctor is subject to the UR/IMR process writing "Contrary to the applicant's contentions, by its adoption of the MPN system, the Legislature did not evidence the intent to preclude a defendant from seeking UR review of an MPN physician's request for authorization of medical treatment." Also reaffirming that Rule 9792.10.1(4)(A)-(F) provides that where the MTUS is "silent and there is no peer-review scientific and medical evidence, the reviewer may consider nationally recognized professional standards, expert opinion, generally accepted standards of medical practice and treatment that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious". See also, accord, opinion granting reconsideration for further consideration Hogenson v. Volkswagen Credit, Inc. AIG Claims San Diego, AJD2145168, (6/18/14 Oxnard District Office);

decision. Last, where a defendant's UR is found invalid, the issue of medical necessity is not subject to IMR, but is to be determined by the WCAB based upon substantial medical evidence, with the employee having the burden of providing the treatment is reasonably required.

On further reconsideration the WCAB by En Banc decision reversed holding that medical necessity may only be addressed by the WCJ where the UR is untimely. In circumstances involving medical necessity the procedure is limited to the UR/IMR process and is not subject to expedited hearing or other proceedings before the WCAB.

See also, Glendale Adventist Medical Center v. WCAB (Gibney) 79 CCC 1544, 2014 Cal.Wrk.Comp. LEXIS 158, where medical necessity proper issue at expedited hearing where UR untimely despite treatment for contested part of body where award of medical treatment was reasonable and necessary (LC 4600) to cure or relieve accepted part of body. See also, accord, Sanchez v. Enterpriase Rent-A-Car 2014 Cal.Wrk.Comp.P.D. LEXIS 596.

See also, Flores v. Hvolvoll-Johnson Construction 2014 Cal.Wrk.Comp.P.D. LEXIS 471, where defendant only raises jurisdiction/authority of WCAB to determine timeliness and medical necessity on reconsideration, the holding of WCJ on UR timeliness and medical necessity upon a finding of untimely UR will be upheld.

Torres vs. Contra Costa Schools Insurance Group, SCIF (2014) 79 CCC 1181, 2014 Cal.Wrk. Comp. LEXIS 111 (Significant Panel Decision)

Applicant sustained injury to left knee, neck and spine which caused a need for medical treatment. The PTP requested further authorization for Duragesic patches and Norco. Defendant's UR physician certified the Norco but conditionally denied the Duragesic patches pending submission of additional information to include whether other medications had been tried, whether applicant has a history of opioids use, and most recent lab tests. The UR physician went on to specially write that "the conditional non-certification represents an administrative action taken to comply with regulatory time frames constraints, and does not represent a denial based on medical necessity," and that the request for authorization for Duragesic patches will be reconsidered upon receipt of the information requested." Defendant did not send further information to the UR physician and denied the request for Duragesic patches. Applicant timely submitted an application for IMR on 8/1/13 and a further report by the PTP addressing opioid history and prior use of Duragesic patches. The IMR determination dated 11/12/13 provided without explanation that the Duragesic patches were "not medically necessary and appropriate". Applicant's Counsel sought appeal to the Administrative director writing that the "[IMR] reviewer failed to review documents submitted by applicant and applicant's representative before making the determination "contrary to applicant's right to due process", applicant's attorney also filed a DOR for expedited hearing. Although the appeal was signed by applicant's representative it was not verified. At expedited hearing the WCJ dismissed applicant's appeal for lack of verification.

Labor Code section 4610(h) requires that a determination of the administrative director "may be reviewed only by a verified appeal from the medical review determination of the administrative director". The verification requirement found in LC 4610(h) is consistent with the WCAB Rules of Practice and Procedure, Rule 10450(a) which requires that all petitions and answers be verified and failure to verify is a valid ground for summary dismissal. The Board, went on however, to note that it has "long been recognized that lack of verification does not necessitate automatic dismissal of nonconforming pleadings". *(See United Farm Workers v. Agricultural Labor Relations (1985) 37 Cal.3rd 912, 915).* Even so noted the court, "failure to correct a lack of verification within a reasonable time after receiving notice of the defect allows dismissal of the nonconforming petition." Noting that the verification requirement is relatively new, and that there is a strong public policy favoring the disposition of cases on the merits, the finding of dismissal of appeal by the WCJ at expedited hearing is reversed.

Bodam v. San Bernardino County/Department of Social Services (2014) 79 CCC 1519, 2014 Cal.Wrk.Comp LEXIS 156 (Significant Panel Decision)

Applicant, who was represented, sustained injury to his low back on 3/24/11. Dr. Cheng, after conducting an examination for the purpose of evaluating the applicant's need for surgery, faxed a RFA to defendant's adjuster (SCIF) on 10/28/13 requesting authorization for a three level fusion. SCIF sent the RFA to its UR agent the same day. On 10/31 the UR agent made its determination to deny the request. On 11/5/13 defendant mailed written denial letters to applicant, applicant's counsel and to Dr. Cheng. At expedited hearing no evidence was presented that the UR decision was communicated to Dr. Cheng by fax, phone or email within 24 hours of the decision, nor any evidence that written notice was provided within two business days of the decision to applicant, applicant's physician or attorney. Applying

Dubon II the WCJ found the UR decision, although timely decided, was not timely communicated and therefore the issue of medical necessity was properly before the WCJ. The WCJ then order the parties to develop the medical record on the issue of medical necessity for surgery. Defendant sought removal.

Labor Code 4610(g)(1) provides that the UR decision must be made within "five working days from receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician". Further, under LC 4610(g)(3)(A), the decision must be communicated to "the requesting physician within 24 hours of the decision" by fax, phone or email and in writing within two business day to physician, employee, and if represented counsel.

AD Rule 9792.9.1(e)(3) provides, "For prospective, concurrent, or expedited review, a decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request."

Editor's comments: Note that LC 4610(g)(3)(A) only requires that the UR decision be communicated either within 24 hours by fax or electronically or in writing within 2 business days but not both. AD Rule 9792.9.1(e) seems to require both?? Also for the first time the WCAB has upheld the parties' right to agree to utilize an AME on medical treatment issue rather than utilizing the UR/IMR process. (See, Bertrand v. County of Orange 42 CWCR 20 (ADJ3135829)(BPD)

In upholding the WCJ, the WCAB wrote that (1) a defendant is obligated to comply with all time requirements in conducting UR, including timeframes for communicating the UR decision; (2) a UR decision that is timely made but not timely communicated is untimely; (3) When a UR decision is untimely for any reason, it is invalid and the issue of medical necessity may properly be decided by the WCAB based upon substantial evidence, citing *Dubon II.* Removal denied.

McFarland v. The Permanente Medical Group, Inc., adjusted by Athens Administrators, Inc., 2015 Cal. Wrk. Comp. P.D. LEXIS 23(BPD).

Applicant, while employed as a registered nurse sustained injury to her thoracic spine, cervical spine, chest, abdominal wall, left shoulder, respiratory system, and in the form of hypertension and damage to the aorta ultimately resolved via Compromise and Release with "open" medical care for $300,000 based on the opinion of QME Steven Isono that the applicant was totally permanently disabled. Later the parties proceeded to trial on the issue of applicant's need for a epidural steroid injection. Defendant had denied this treatment based upon a timely and proper UR. It was Applicant's position that the UR physician had been furnished an insufficient medical record from which to determine the reasonableness of the treatment and that the UR therefore suffered from a "material procedural defect" within the meaning of Dubon v. Workers' Compensation Appeals Board (2014) 79 Cal.Comp.Cases 313 [hereafter, Dubon I]. Subsequently in *Dubon II*, the Appeals Board held that a timely UR decision must be reviewed through the independent medical review (IMR) process rather than by the WCAB. With respect to applicant's contention that the denial of applicant's ability to appeal a noncompliant UR decision is unconstitutional, the WCAB has no

*". . .*Labor Code section 4604.5 states that the MTUS "shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof."

Whether a party has rebutted a presumption affecting the burden of proof is a legal question and the determination of a legal question must be made by a court. "A presumption is an assumption of fact that the law requires to be made from another fact or group of facts found or otherwise established in the action. A presumption is not evidence." (Evid. Code § 600(a).) '"Preponderance of the evidence' means that evidence that, when weighed with that opposed to it, has more convincing force and the greater probability of truth." (Lab. Code § 3202.5.)

Pursuant to a constitutional grant of authority (Cal. Const., art. XIV, §§ 1, 4), the Legislature created the WCAB and vested it with judicial powers. (Lab. Code, § 111.) The Legislature further gave the WCAB the "full power, authority, and jurisdiction to try and determine" all workers' compensation claims and any right or liability arising out of or incidental thereto. (Lab. Code, § 5301, see also Lab. Code, § 5300.) The WCAB is the court with jurisdiction to determine whether a party to a workers' compensation case has met its burden of proof and rebutted a presumption found in division four of the Labor Code. (*Honeywell v. Workers' Comp. Appeals Bd.* (2005) 35 Cal. 4th 24 [70 Cal.Comp.Cases 97]; *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418 [67 Cal.Comp.Cases 236].)

The Legislature specifically vested the WCAB with jurisdiction over any controversy relating to or arising out of Labor Code sections 4600 to 4605 inclusive. (Lab. Code § 5304.) Labor Code section 4604 states that "['controversies between employer and employee arising under this chapter shall be determined by the appeals board. . .except as otherwise provided by Section 4610.5." Thus, a challenge to the presumptively correct MTUS as set forth in Section 4604.5 is within the jurisdiction of the WCAB. In contrast, Section 4610.5 applies to independent medical review of disputes over UR decisions and is outside the purview of Section 4604 and, accordingly, 5304. Interpreting these statutes together, an applicant may attempt to rebut the MTUS and must be provided with an opportunity to adjudicate whether he or she has rebutted the MTUS under Labor Code section 4604.5 separate from the UR/IMR process discussed in Dubon II.

authority to determine the constitutionality of the IMR statutes as sought by applicant. (*Greener v. Workers' Comp. Appeals Bd* (1993) 6 Cal.4th 1028 [58 Cal.Comp.Cases 793]; *Niedle v. Workers' Comp. Appeals Bd.* (2001) 87 Cal.App.4th 283 [66 Cal.Comp.Cases 223].) Based on *Dubon II* the WCAB upheld the WCJ finding that the WCAB had no jurisdiction to award the disputed medical treatment.

However, in a succinctly written dissent, Commissioner Margaret Sweeney proposed that applicant should be allowed to rebut MTUS guidelines before WCAB, because although Labor Code § 4604.5 provides that MTUS guidelines are presumptively correct, it does not provide procedure for determining whether scientific medical evidence establishes that variance from guidelines is reasonably required to cure or relieve injured worker from effects of industrial injury. Commissioner Sweeney maintained that whether party has rebutted presumption affecting burden of proof is a legal question that must be determined by court of law, as such determination requires weighing of facts and evidence, that Labor Code §§ 4604 and 5304, together, give WCAB jurisdiction to determine medical treatment guideline controversies arising under Labor Code § 4604.5, independent from procedures in Labor Code § 4610.5 and *Dubon v. World Restoration, Inc.* (2014) 79 Cal. Comp. Cases 1298 (Appeals Board en banc opinion) (*Dubon II*), which apply to UR/IMR process for resolving "medical necessity" issues based on established guidelines, that UR decision here denied applicant's medical treatment based upon MTUS, and that, therefore, applicant should be entitled to present evidence that she rebutted MTUS before the WCAB.

> *". Contrary to Labor Code sections 5304 and 4604.5, applicant has not been provided a forum to rebut the Administrative Director's medical treatment utilization schedule (MTUS). In contrast to 4604.5 and the legal concept of rebuttal, Labor Code Section 4610.5 establishes a methodology which the independent medical reviewer must follow to determine the "medically necessity" of a treatment request that was not approved by a UR decision. It requires the application of tiered standards applied in ranked order, "allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition" and the highest ranked standard is "guidelines adopted by the administrative director pursuant to Section 5307.27. [1](Lab. Code § 4610.5(c)(2) and (c)(2)(A).) Thus, the IMR process itself is not and cannot be a forum where, a statutory legal presumption may be challenged or rebutted, according to the plain language of 4610.5(c).*
>
> *Rebuttal is not a medical issue but a legal issue that must be determined by a court. The right of rebuttal is guaranteed by Labor Code Section 4604.5. Labor Code sections 5304 and 4604 give the WCAB jurisdiction to determine controversies relating to or arising out of Labor Code section 4604.5 which states that the MTUS is rebuttable. Here, the utilization review decision denied applicant's medical treatment based upon the MTUS (specifically, subdivisions (b) and (c) of section 9792.25 which is part of the MTUS). (Cal. Code Regs., tit. 8, § 9792.21.) Accordingly, applicant is entitled to present evidence that she has rebutted the MTUS. . . "*
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> *See also, Arredondo v. Tri-Modal Distribution Services, Inc., State Compensation Insurance Fund, Defendants, 2015 Cal. Wrk. Comp. P.D. LEXIS 209, 2015 Cal. Wrk. Comp. P.D. LEXIS 209, which held by split panel decision that untimely completion of IMR by Adminstrative Director does not remove medical necessity to WCAB. Reasons given were that (1) Legislature requires medical treatment disputes to be evaluated through IMR in order to assure that medical necessity is objectively and uniformly determined based on Medical Treatment Utilization Schedule (MTUS) and other recognized standards of care, (2) IMR determination is governmental action performed under auspices and control of Administrative Director, distinctly different from UR where defendant is obligated to perform within statutory and regulatory framework, (3) Legislature provided guidelines in Labor Code § 4610.6(d), administrative in nature, addressing when IMR determination should issue, but it enacted no provisions that invalidate IMR determination if determination is not made within Labor Code § 4610.6(d) timeframes, (4) given statutory design of IMR, Labor Code § 4610.6(d) timeframes are directory and not mandatory, and, therefore, IMR determination is valid even if it does not issue within specified timeframes, (5) untimeliness is not listed as ground for IMR appeal in Labor Code § 4610.6(h), and (6) because no grounds for appeal of IMR determination under Labor Code § 4610.6(h) were established at trial, IMR determination in this case was final and binding on applicant. But see contra, Saunders v. Loma Linda University Medical Group, PSI, Defendant, 2015 Cal. Wrk. Comp. P.D. LEXIS 311, 2015 Cal. Wrk. Comp. P.D. LEXIS 311.*

Garraway-Jimenez, v. Santa Barbara Medical Foundation Clinic, Zurich American Insurance, Defendants, 2015 Cal. Wrk. Comp. P.D. LEXIS 130.

Applicant sustained CT injury to cervical spine and elbows for the period ending 10/10/05. Defendant denied a request for left ulnar nerve decompression based upon timely Utilization Review (UR) denial. Although both the treater and the AME supported the surgery, defendant failed to provide the report from either to the UR or IMR physicians, or electrodiagnostic studies performed on June 4, 2014, and existing records as well as a supplemental report by the recommending surgeon, Dr. Ruth. An expedited hearing was held on January 27, 2015. The WCJ concluded that it was applicant's failure to timely forward the medical records that prevented the IMR reviewer from considering the AME reports, such that any error on the part of IMR was self-inflicted by applicant; and that since the error was caused by applicant's oversight and inadvertence, it would be unreasonable to force defendant to provide another IMR Determination.

> *Editors' Comments: Although the Garraway-Jimenez case was a win for the applicant, it demonstrates the real problem with the IMR process – the potential for delay without any real consequence to the defendant.*

On reconsideration/removal the WCAB reversed citing LC 4610.5(i) and Rule 9792.10.5, both of which

require the defendant/representative to provide "all relevant medical records". The WCAB held that defendant's "failure to provide the IMR reviewer with all material and relevant medical records, the determination of the IMR organization, and thus the Administrative Director, was an act without or in excess of its powers. The IMR process can only work if the parties meet their obligation to provide the necessary medical records. The WCJ's determination that it would be unfair to defendant to require it to pay for another IMR appeal fails to recognize that it is defendant, not applicant, who is mandated to provide the medical records for the IMR Determination. Under these circumstances, unfairness to defendant is not a valid basis upon which to make a determination, where defendant has not met its statutory obligation to serve medical records." Reversed and remanded.

Stevens v. WCAB (Otuspoken Enterprises et al.,) (2015 1st Appellate District) __ CCC ___

Applicant sustained injury to right foot in October 1997 and subsequently underwent three surgeries. Ultimately the applicant was diagnosed with complex-regional-pain syndrome to bilateral feet. The bilateral foot pain ultimately forced the applicant from continuing to work and into a wheelchair. The applicant also sustained as a compensable consequence injury to low back, bilateral shoulders and ultimately depressions which all combined to result into a total award of disability. The applicant's PTP requested authorization for pain medications and in-home health aide 8 hours a day five days a week. The home health aide was to help the applicant with bathing, dressing, ambulation, meals and picking up prescription medications. The request was timely submitted by the defendant to UR which was not certified, with a proper notice provided by defendant to applicant. Applicant requested an internal review submitting additional records and information, but the internal review also denied authorization. Applicant next requested an IMR which upheld the original UR determination. Next, the applicant appealed the IMR determination to the Board pursuant to LC 4610.6(h) raising constitutional issues including violation of Section 4 of the State Constitution and the applicant's right to due process. The WCJ held that none of the grounds for appeal applied and that the Board had no jurisdiction to consider the constitutionality of LC 4610.6. Then the applicant sought reconsideration by the WCAB who adopted the decision of the WCJ. The applicant then petitioned for a writ of review raising constitutional challenges.

In addressing and denying the applicant's petition, the Court on eight separate occasions noted that the "state Constitution gives the Legislature 'plenary power. . .to create and enforce a complete system of workers' compensation. . ." noting that "the underlying premise behind this statutorily created system. . .is the 'compensation bargain' under which the 'employer assumes liability for industrial personal injury or death without regard to fault in exchange for limitations on the amount of that liability. Next, the Court noted that the legislature intent behind SB 228 and 899 was to "steamline the process and control costs", with the system to resolve disputes over medical treatment existing prior 1/1/13 being "costly, time consuming, and did not [produce] uniform results." The Court discussed at length the procedures available to the applicant under the UR/IMR procedures noting (1) only the applicant may request review of an adverse UR determination by IMR; (2) the IMR reviewer reviews pertinent medical records, provider reports and other information submitted by the parties; (3) the standard for review includes MTUS, peer-reviewed scientific and medial evidence regarding the effectiveness of the disputed treatment, nationally recognized professional standards etc. (4) although the IMR reviewer's name is kept confidential, the decision must include the reviewer's professional qualification; (5) A worker may dispute through appeal to the Board under specified grounds, and (6) where the applicant is successful the remedy is a new IMR; and further (7) the Boards decision can always be challenged by writ of review to the Court of Appeal.

The Court also noted that the UR/IMR procedure now "guarantees that the UR decision rendered in [applicant's] favor could not be challenged by employers on medical-necessity grounds" . . . "ensuring faster final resolution of these decisions" . . . "and constituted a meaningful curtailment of the employers' rights" in exchange of the promised reduction in insurance costs "by creating uniform medical standards". In the end the Court of Appeal held that the Legislature had "Plenary Powers" over the Workers' Compensation System are (1) not limited by the State Constitution's separation of powers or due process clauses; (2) Nor does the IMR process violate Section 4's requirement that tribunal decisions be subject to review by appellate courts; (3) Nor does the IMR process violate Federal Due Process requirements. During this past February the California Supreme Court denied review.

McBurney, Applicant v. All That Glitters, Employers Compensation Insurance Company, 2015 Cal. Wrk. Comp. P.D. LEXIS 637 (Panel Decision)

Applicant sustained injury to on 12/8/04 to left knee when he fell from a ladder. Primary treating physician Michael Laird, M.D., signed an RFA dated March 24, 2014, requesting authorization for left total knee arthroplasty. The subject treatment was supported by the opinion of the AME. The RFA contains a date stamp of March 24, 2014, along with a hand-written note that says: "This was faxed to WC on 3/24/14 [with] Dr. notes"; "KR/Dr. Laird." Defendant issued a UR decision on April 16, 2014, which denied the request for left total knee arthroplasty. The UR decision states that the RFA was received on April 7, 2014. Defendant also produced an email from its UR agency dated April 10, 2014. The email indicates that the RFA was first received by the adjuster on April 7, 2014, and that April 7 was the date of first knowledge of the RFA. Defendant did not produce a copy of the RFA it received with an electronic date stamped receipt. The April 16, 2014 UR decision was served at an old address on Boeker Street in Pismo Beach, CA. According to EAMS, the application for adjudication, and as set forth in applicant's petition, applicant has lived in Nipomo, CA for approximately eight years.

". Applicant claims that the RFA for left knee arthroplasty was transmitted on March 24, 2014. Defendant claims to have received it on April 7, 2014. To determine whether UR was timely conducted, we must determine when the RFA was received by the adjuster and/or transmitted to the adjuster. We must also determine who has the burden of proving when the RFA was received and/or transmitted and delineate exactly how that burden is proven. The controlling regulation in making this determination is WCAB Rule 9792.9.1(a)(1), which states:

> *(1) For purposes of this section, the DWC Form RFA shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or the claims administrator's utilization review organization. A DWC Form RFA transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review. The copy of the DWC Form RFA or the cover sheet accompanying the form transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display the facsimile telephone number to which the form was transmitted. The requesting physician must indicate if there is the need for an expedited review on the DWC Form RFA. (Cal. Code Regs., tit. 8, § 9792.9.1(a)(1).)*

The preferred method for proving when an RFA is received is to produce a copy of the RFA with an electronic date stamp showing precisely whe the RFA was received by defendant. If defendant produces a copy of the RFA with an electronic date stamped receipt, the dated receipt will be prima facie evidence of the date received. No such evidence was offered in this case.

If a fax or email receipt does not exist, then we must determine if and when the RFA was transmitted. The evidence of transmission must consist of one of the following documents: (1) a copy of the RFA, or (2) the fax cover sheet accompanying the RFA, or (3) the email that transmitted the RFA. Whichever document is used, the document must contain either: (A) the date, time, and place of transmission and the fax number or email address to which the RFA is sent, (B) an unsigned copy of the affidavit or certificate of transmission, or (C) a fax or electronic mail transmission report confirming that the RFA was sent.

Applicant did not meet his burden of proving that the RFA was transmitted to defendant on March 24, 2014. Applicant produced a copy of the March 24, 2014 RFA. (Exhibit 5). However, the only indication that the RFA was faxed is a hand-written note, which is missing the time of transmission. Applicant did not produce sufficient evidence that proves the RFA was transmitted on March 24, 2014.

Defendant also failed its burden of proving receipt of the RFA on April 7, 2014. There was a two-week gap in time from the claimed transmission of the RFA to the claimed receipt of the RFA. Given the clear discrepancy in evidence in this case, we ordered the production of additional evidence and specifically requested that defendant produce an electronically date stamped copy of the RFA as it was received by defendant. Defendant did not produce any such evidence.

We clearly requested in our August 11, 2015 Order that the parties provide copies of the March 24, 2014 RFA with electronic date stamps. However, after providing both parties a second chance to meet their respective burdens of proof, neither applicant nor defendant provided substantial evidence documenting transmission or receipt of the March 24, 2014 RFA. Absent such evidence we cannot determine whether defendant timely completed UR based on the transmission or receipt date of the RFA. [2] However, as explained below, the parties' failure to prove transmission / receipt of the RFA is not dispositive of the timeliness issue in this case.

WCAB, held that although the applicant had failed to establish defendant's utilization review was untimely since applicant failed to (1) produce copy of RFA with electronic date stamp showing precisely when RFA was received by defendant and that dated receipt is prima facie evidence of date received, (2) or where a fax or email receipt does not exist, evidence of RFA transmission which may include document showing date, time and place of submission and fax number or email address to which RFA is sent, or unsigned copy of affidavit or certificate of transmission, or fax or electronic mail transmission report confirming RFA was sent; And a handwritten note indicating that RFA was faxed, without time of transmission, is insufficient evidence to prove date and time that RFA was transmitted. However, a parties' failure to produce substantial evidence documenting transmission or receipt of RFA was

not dispositive of timeliness issue in this case because UR decision was untimely under 8 Cal. Code Reg. § 9792.9.1(e)(3) and Bodam v. San Bernardino County/Department of Soc. Servs. (2014) 79 Cal. Comp. Cases 1519 (Appeals Board significant panel decision), based on defendant's failure to timely serve decision because defendant did not serve applicant at his official address of record and did not serve decision on Dr. Laird, and reasonableness of treatment was supported by agreed medical examiner's opinion and Medical Treatment Utilization Schedule.

"...Regardless of when the RFA was received by defendant, we still find that the UR decision is untimely because defendant failed to timely serve the decision. Rule 9792.9.1(e)(3) states:

> *For prospective, concurrent, or expedited review, a decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request. (Cal. Code Regs., tit. 8, § 9792.9.1(e)(3).)*

In this case UR was completed on April 14, 2014. Defendant has the burden of proving that it served the UR decision appropriately. Defendant failed to serve the UR decision on applicant as it did not serve applicant at his official address of record, but sent the decision to an old address that applicant had not occupied for approximately eight years. Next, the UR decision in evidence contains no proof of service on Dr, Laird. (Exhibit C.) The first page of the document states that it was faxed to Dr. Laird; however the electronic date stamp on the document is April 23, 2014. (Id.) Defendant has failed to prove the UR decision was timely served on applicant and Dr. Laird. Defendant's UR decision was untimely served and thus it is invalid."

Editor's Comments: Regardless of how the WCAB reached their decision in McBurney, or the holding on the burden of proof, a defendant should be reminded that it is the defendant who this editor believes has the burden of proof on establishing that the UR determination is timely and notice of UR determination was timely and properly served, for it is the defendant who benefits from the affirmative on both issues. Also noteworthy is that the Court in Footnote 2 provided that, "On a case by case basis, the court may wish to analyze whether a UR's timeliness can be determined by Rule 9792.9.1(a)(2)(C), which states: "In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the DWC Form RFA shall be deemed to have been received by the claims administrator five days after the latest date the sender wrote on the document." (Cal. Code Regs., tit. 8, § 9792.9.1(a)(2XC).) However, we need not apply that rule in this matter as the UR decision was not timely served."

See also, Hacker v. County of San Bernardino (2015) 2015 Cal.Wrk.Comp.P.D. LEXIS 415 holding that IMR determination need not list specific date of each report reviewed, listing documents reviewed by name of provider and range of provider's date of service is sufficient.

See also, Herring v. Paradise Valley Hospital (2015) 2015 Cal.Wrk.Comp.P.D. LEXIS 526 where WCJ was directed to address medical necessity where UR determined to be untimely even where drug prescription was stale by the time the issue came before the WCJ due to delays resulting from the UR process and litigation.

B. Miscellaneous UR Provisions

Effective Period of UR Denial: Absent a documented change in the facts material to the basis of the UR decision, the UR decision shall remain effective for 12 months from the date of the decision. Lab. Code §4610(g)(6)

Expedited Review -- Imminent and serious threat to health: expedited review decision to authorize must be made within 72 hours of receipt of information reasonable necessary to make the determination. Lab. Code §4610(g)(2). Rule 9792.9.1(c)(4).

Jesus Rodriguez v. Air Eagle, Inc., California Insurance Guarantee Association, Sedgwick CMS for Legion Insurance In Liquidation, Defendants, 2015 Cal. Wrk. Comp. P.D. LEXIS 3 (BPD).

Applicant sustained industrial injury to his right elbow, right shoulder, psyche, right hand grip loss, and neck on December 29, 2000. An issue arose whether the applicant was in need of 24/7 home health care due to severe depression and three psychiatric hospitalizations for suicide attempts in 2004 and 2005, although he had not made any subsequent suicide attempts and was not actively suicidal at time of his DQME evaluation in April 2008. During March 7 to March 21, 2013 applicant was again hospitalized "after disclosing his plans of jumping out of a moving vehicle to end his life." (*Ibid.*) Upon discharge the PTP recommended that applicant have 24 hours per day, 7 days per week of home health care services "preferably by a psyche technician or LVN level. On October 28, 2013, the PTP submitted a Request for Authorization for Medical Treatment (RFA) to defendant. The form is electronically date-stamped "10/28/2013 2:53:13 PM." The box which states: "Check box if the patient faces an imminent and serious threat to his or her health" was checked. The requested procedure is "24/7 home health care by psyche tech or LVN." The RFA was signed by the PTP. On November 6, 2013, a UR decision issued denying the requested home health care services. On November 7, 2013, defendant's adjuster wrote to PTP and advised of four UR decisions, including the request for home health care services. The WCJ found for the defendant that the UR was timely as made 9 days from the request.

". We first address whether the UR decision of November 6, 2013 was invalid. In Dubon II, we held that a UR decision is invalid only if it is untimely. (Id. at p. 1299.) Accordingly, we consider former Rule 9792.9.1 which set forth the timeframes for UR decisions at the time that the subject RFA was submitted and one UR decision issued. (See Cal. Code Regs., tit. 8, § 9792.9.1, operative October 1, 2013.) [1] *According to then Rule 9792.9.1(a)(1), the RFA is deemed to have been received "on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or the claims administrator's utilization review organization." (Cal. Code Regs., tit. 8, § 9792.9.1(a)(1).) Here, the October 28, 2013 RFA was electronically date-stamped "10/28/2013 2:53:13 PM" (Exhibit E), and defendant's adjuster testified that she received the RFA on October 28, 2013. Thus, the operative date is October 28, 2013 at 2:53 p.m. The UR decision issued nine days later on November 6, 2013, and the WCJ concluded that defendant's UR decision was timely because it issued within the time requirements for a regular UR decision.*

However, Dr. Hekmat checked the box for imminent and serious threat on the RFA, thereby raising the issue of whether the October 28, 2013 RFA was subject to the timelines for expedited review. According to then Rule 9792.9.1(c)(3)(A), "Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify the need for an expedited review upon submission of the request." (Cal. Code Regs., tit. 8, § 9792.9.1(c)(3)(A).) Here, both defendant's adjuster Ms. Valencia-Friend and defendant's UR reviewer Ms. Laubach testified that the RFA of October 23, 2013 was correctly filled out and that the RFA was complete when it was received on October 28, 2013. As part of the RFA, Dr. Hekmat attached his September 26, 2013 report which was signed under penalty of perjury. The purpose of the box check is to alert the reviewer that a separate timeframe for the decision applies, and there is nothing in Rule 9792.9.1 as it existed in 2013 which allows a defendant to override a requesting physician's designation of a request as imminent and serious. Thus, the October 28, 2013 RFA should have been treated as an expedited request.

For . . . expedited review, a decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician . . . within 72 hours of receipt of the request [for expedited review]. (Cal. Code Regs., tit. 8, § 9792.9.1(e)(3).) "The first day in counting any timeframe requirement is the day after receipt . . . except when the timeline is measured in hours . . . [then] the time for compliance is counted in hours from the time of receipt of the DWC Form RFA." (Cal. Code Regs., tit. 8, § 9792.9.1(c)(1).) Here, 72 hours after October 28, 2013 at 2:53:13 p.m. is October 31, 2013 at 2:53:13 p.m. The request for further information was sent on November 1, 2013, and both Ms. Valencia-Friend and Ms. Laubach admitted that defendant did not meet the 72 hour timeframe. Accordingly, the UR decision of November 6, 2013 was untimely. "

Editor's comments: In an effort to avoid the UR/IMR process we can now expect that applicant attorneys might now seek to have the requesting physician seek an expedited review which simply requires the request be reasonably supported by evidence establishing that the injured worker faces "an imminent and serious threat to his or her health", or that the "timeframe for utilization review under subdivision (c)(3) & (f)(3) (5 days) would be "detrimental to the injured worker's condition" which shorten the period of review from 5/14 day period to within 72 hours of receipt of information reasonable necessary to make the determination. (Lab. Code §4610(g)(2); Rule 9792.9.1(c)(4))

Applicant sought reconsideration asserting that the UR was untimely as expedited review was requested and pursuant to Rule 9792.9.1(c)(3)(A) *(currently Rule 9792.9.1.(c)(4)*, the decisions to approve, modify, delay, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination.

Recon granted.

Penalties: 5814 penalties inapplicable during the UR process absent an unreasonable delay in completion of the UR process. Lab. Code §4610.1.

Rescission of Authorization: Rescission after treatment provided prohibited. Lab. Code §4610.3

III. The UR-IMR Process

A. Basic Timeline for UR-IMR

Request for IMR must be submitted to the AD **within 30 days after service of the UR decision**. *Lab. Code §4610.5(h)(1)*. IMR final determination must be made within thirty (30) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information. *Cal. Code Regs., tit. 8, §9792.10.6(g)(1).*

See also, McKinney v. Enterprise Rent-A-Car of San Francisco, 2016 Cal. Wrk. Comp. P.D. LEXIS 495 (BPD), which held that Administrative Director Rules 9785(g) and 9792.6.1(t)(2) which requires the RFA to include documentation substantiating the need for the requested treatment, but it is the primary treating physician, and not a claims adjustor, who knows what medical records substantiate the requested treatment. Therefore, the defendant's failure to take the initiative and submit applicant's complete medical record to the UR doctor will not constitute a willful failure to comply with its regulatory and statutory obligations, nor an indication of a bad faith tactic that is frivolous or solely intended to cause delay justifying the impositions of 5813 sanctions. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][f], 22.05[6][b][v], 23.15; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10, Ch. 16, § 16.35[2]. Sullivan on Comp, Section 7.34 Utilization Review – Requests for Authorization]

Exception to 30 day request requirement: where dispute over issues other than medical necessity, ie. liability dispute, than IMR request must be submitted by the applicant within 30 days of notice to the employee showing that the other dispute is resolved. *Lab. Code §4610.5(h)(2).*

AD makes determination of eligibility/appropriateness for IMR request involving issues of timeliness, completeness of application for IMR, previous requests, assertion by claim's administrator contesting liability for injury or part of body, etc. *Lab. Code 4610.5(k); Cal. Code Regs., tit. 8, §9792.10.3.* AD may request additional information/documentation from the parties which is required to make eligibility determination, parties to reply/provide within 5 days of request. *Cal. Code Regs., tit. 8, §9792.10.3(c).* Appeal of eligibility determination of the AD may be made by either party upon petition to the WCAB Commissioners. *Cal. Code Regs., tit. 8, §9792.10.3(e).*

Treatment Authorization: If IMR approves treatment request, it must be authorized within 5 working days or sooner. *Cal. Code Regs., tit. 8, §9792.10.7(a)(2).*

Lambert v. State of California Department of Forestry, SCIF, 2016 Cal. Wrk. Comp. P.D. LEXIS 492 (BPD)

Applicant sustained an admitted injury to his left knee on February 7, 2015, while employed as a firefighter by California Department of Forestry and Fire Protection. Applicant's PTP performed a surgical repair of the medial meniscus on October 24, 2015. Applicant was provided physical therapy prior and subsequent to his surgery. The parties stipulated that applicant had at least 28 post-operative physical therapy visits. Applicant's PTP submitted an RFA for an additional eight physical therapy visits. Defendant's claims adjuster issued a denial of the request on May 26, 2016, citing the 24 physical therapy visit cap in Labor Code section 4604.5(c)(1). The additional RFA of 8 PT visits was not submitted to UR, rather the adjuster relied on a pre-surgical denial based upon pre-surgical PT totaling 24 visit. Applicant's attorney responded on May 31, 2016, noting that the 24 visit cap on physical therapy cited by defendant's claims adjuster was not applicable to post-surgical physical therapy, and he demanded that defendant immediately authorize the requested treatment. The matter was submitted on this record at an expedited hearing.

"Labor Code section 4604.5(c)(1) sets a 24 visit cap on physical therapy visits "notwithstanding the medical treatment utilization schedule." However, this cap is not applicable to physical therapy visits for "postsurgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27." (Labor Code section 4604.5(c)(3).)

Applicant was correct in asserting that since this was a postsurgical treatment request, SCIF's claims adjuster erroneously relied on the 24 visit cap in Labor Code section 4604.5(c)(1) when he denied Dr. McLennan's request.

When considering requests for medical treatment for post-surgical knee complaints, the MTUS provides:

> *(d) If surgery is performed in the course of treatment for knee complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply. (Cal. Cod Regs., tit. 8, section 9792.23.6 Emphasis added.)*

When a treating physician submits a Request for Authorization for medical treatment to a claims adjuster, Labor Code section 4610(e) provides that only a licensed physician "may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve." Thus a reviewing physician, and not a claims adjuster, is required to apply the MTUS when determining the medical necessity of a proposed medical treatment. (Labor Code section 4610(f).)"

Lambert v. State of California Department of Forestry, 2016 Cal. Wrk. Comp. P.D. LEXIS at pg. 494

See, Garcia, v. American Tire Distributors, Broadspire, 2016 Cal. Wrk. Comp. P.D. LEXIS 527 (BPD), where the Board held that an agreement between the parties to resolve a single medical issue through the use of an AME pursuant to LC 4062(b) cannot be used to avoid application of the UR/IMR process pursuant Labor Code §§ 4610 and 4610.5. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11. Sullivan on Comp. Section 7.36, Utilization Review -- Procedure]

See also, Hogenson v. Volkswagen of America, Insurance Company of the State of Pennsylvania, 2016 Cal. Wrk. Comp. P.D. LEXIS 488 (BPD, holding that RFA from MPN treating physician is subject to UR/IMR process, which is consistent with the legislative goal of assuring that medical treatment is provided by all defendants consistent with uniform evidence-based, peer-reviewed, nationally recognized standards of care; Commissioner Sweeney concurring separately noted two separate statutory tracks to dispute recommendation of MPN treating physician, consisting of UR IMR (employer objects) and second opinion MPN IMR process (applicable when employee objects); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]. Sullivan on Comp, Section 7.55, Medical Provider Network – Dispute Resolution]

See also, Rivas v. North American Trailer, 2016 Cal. Wrk. Comp. P.D. LEXIS 572 (BPD) holding that Applicant may properly select individual physician not individually listed on employer's MPN where physician's medical group is listed, and MPN medical groups employs services of physicians who do not register individually with MPN; WCAB interpreting Labor Code § 4616(a)(3) and 8 Cal. Code Reg. § 9767.5.1. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[2]. Sullivan on Comp, Section 7.53, Medical Provider Network.]

The WCJ held that when treating physician submits RFA for medical treatment, the UR Physician, not claims adjuster, is required to apply MTUS to determine medical necessity of proposed treatment, and that since application of MTUS post-surgical guidelines was required to determine whether additional physical therapy visits were medically necessary to treat applicant's injury, it was beyond claims adjuster's authority to apply MTUS to deny treating physician's RFA, and RFA should have been submitted to UR for review by licensed physician. However, Labor Code section 4604.5(c)(1) sets a 24 visit cap on physical therapy visits "notwithstanding the medical treatment utilization schedule." However, this cap is not applicable to physical therapy visits for "postsurgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27." (Labor Code section 4604.5(c)(3).); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d§§5.02[2][a], [b], 22.05[6][b][i], [ii]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10[6].]

See, Gonzalez v. Imperial County Office of Education, 2016 Cal. Wrk. Comp. P.D. LEXIS 528 (BPD), holding that dismissal without prejudice be rescinded where when medical reports established diagnosis of agoraphobia and panic disorder and applicant was medically unable to appear in court; Due process required accommodations such as being permitted to appear telephonically or via Skype [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 26.01[3][b], 26.04[1][c]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.07[2][b]. Sullivan on Comp, Section 15.37, Requirement to Appear at Hearing.]

See, Williams v. Department of Corrections & Rehabilitation, 2016 Cal. Wrk. Comp. P.D. LEXIS 511(BPD) holding that it was error for WCJ to order former counsel to attend hearing as witness rather than by subpoena pursuant to Cal. Code Civ. Proc. § 1985, and the subpoena must be personally served as required by Cal. Code Civ. Proc. § 1987. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 25.10[2][a], 26.03[4], 26.05[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1], Ch. 16, § 16.48[1], Ch. 19, § 19.37. Sullivan on Comp, Section 15.47, Trial – Proceedings and Submission]

See, Bonilla v. San Diego Personnel and Employment dba Good People Employment Services, 2017 Cal. Wrk. Comp. P.D. LEXIS 56 (BPD), holding that treatment requests from all physicians, even those treating within MPN, must go through UR/independent medical review (IMR) process mandated by Labor Code § 4610 et seq., and that existing law requires RFAs for medical treatment be utilized by MPN physicians and are subject to all UR requirements.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]; Sullivan on Comp, Section 7.34, Utilization Review – Requests for Authorization.] See also, Parrent v. Workers' Compensation Appeals Board, Pacific Bell Telephone Co. SBC, 82 Cal. Comp. Cases 155; 2017 Cal. Wrk. Comp. LEXIS 3 (Writ Denied), holding that treatment recommendations of medical provider network treating physician, may only be disputed through utilization review/independent medical review process; Commissioner Sweeney, concurring, wrote separately to emphasize that, even if employer raises dispute with medical provider network treating physician's recommendation and submits issue to utilization review, injured worker may, at same time, exercise his or her right to initiate second opinion process provided in Labor Code § 4616.3 or change treating physicians within medical provider network.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]. Sullivan on Comp, Section 7.55, MPN -- Dispute Resolution]

See also, Thompson v. County of Los Angeles, PSI, 2016 Cal. Wrk. Comp. P.D. LEXIS 107 (BPD) holding that defendant's utilization review (UR) non-certification of treating physician's request for spinal surgery was defective as not timely communicated to applicant's attorney pursuant to 8 Cal. Code Reg. § 9792.9.1(e)(3) and was, therefore, invalid, when defendant communicated UR non-certification to applicant's former counsel rather than current counsel even though defendant should have been aware that applicant was being represented by new counsel as defendant was properly served with copy of substitution of attorney over two years earlier and had been served by new counsel with applicant's change of address, and there was no authority supporting defendant's position that service on applicant's former attorney simply because that attorney appeared on outdated official address record satisfied UR notice requirement. See also, accord, Dallas v. Pan Pacific Petroleum, National Union Fire Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 116 (Panel Decision); Relying on, Bodam v. San Bernardino County/Department of Soc. Servs. (2014) 79 Cal. Comp. Cases 1519 (Appeals Board Significant Panel decision) UR decisions defect for failure communicated both by "telephone or facsimile" to requesting physician within 24 hours of decision and communicated to physician and employee/applicant "in writing" within 24 hours.

a. Documents To Be Provided By Employer Upon Request by Employee for IMR

Essentially all relevant documents must be provided by employer within 15 days of notification of assignment to IMR organization (15 days if notice by mail, 12 if electronically, 24 hours if expedited review). *Lab. Code §4610.5(l) and (n).* The claims professional shall provide to the IMR organization and copied to employee the UR denial, previous six months reports from treater, correspondence with employee involving the treatment at issue, and all documents relevant to the treatment issue. *Cal. Code Regs., tit. 8, §9792.10.5.* (But note conflict in 10 day requirement under *Lab. Code 4610.5(l) and Reg. 9792.10.5* requiring 12-15 days?) By Employee: *Lab. Code 4610.5(f)(3); Cal. Code Regs., tit. 8, §9792.10.5(b)(1)*

IMR organization may request **additional information** from the parties, parties' response due within 5 business days of request, with responding party required to serve response on other party. *Cal. Code Regs., tit. 8, §9792.10.5(c). Lab. Code 4610.5(m).*

Expedited Review: Where there exists an "imminent and serious threat to health of the employee" all necessary information and documentation shall be delivered to IMR organization within 24 hours of approval of request for review. *Lab. Code 4610.5(n); Cal. Code Regs., tit. 8, §9792.10.5(a)(1).* IMR organization shall make decision within 3 days of receipt of IMR Application and documentation. *Cal. Code Regs., tit. 8, §9792.10.6(g)(2)*

b. Penalties For Employer's Delay of IMR Process

An employer who engages in conduct that has the effect of delaying the IMR process shall be subject to an administrative penalty of $5,000 for each day proper notice to employee was delayed. Lab. Code §4610.5(i).

IV. The MPN-IMR Process

MPN Diagnosis or Treatment Dispute: Where employee disputes diagnosis or treatment recommendations, the employee shall send written demand/request for 2nd Opinion from second physician within the MPN. Where the dispute exists after 2nd opinion employee may request 3rd opinion from MPN physician. *Lab. Code 4616.3(c)* and where the dispute persists after the 3rd opinion the applicant may proceed to the IMR process by employee submitting AD Form "Independent Medical Review Application". *Lab. Code 4616.4(b)&(c); Cal. Code Regs., tit. 8, §9792.10.7*

See also, Hogenson v. Volkswagen of America, Insurance Company of the State of Pennsylvania, 2016 Cal. Wrk. Comp. P.D. LEXIS 488 (BPD, holding that RFA from MPN treating physician is subject to UR/IMR process, which is consistent with the legislative goal of assuring that medical treatment is provided by all defendants consistent with uniform evidence-based, peer-reviewed, nationally recognized standards of care; Commissioner Sweeney concurring separately noted two separate statutory tracks to dispute recommendation of MPN treating physician, consisting of UR IMR (employer objects) and second opinion MPN IMR process (applicable when employee objects); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]. Sullivan on Comp, Section 7.55, Medical Provider Network – Dispute Resolution]

a. Procedures: MPN-IMR Procedures after submittal by Employee of AD Form "Independent Medical Review Application".

Following receipt of that application, the employer or insurer shall provide the IMRer with required info. LC 4616.4(d).

Following receipt of documentation, IMRer shall conduct **physical examination** of the EE at EE's discretion. LC 4616.4(e). (Under UR-IMR, IMR an examination is not performed.)

IMR shall issue report to AD within 30 days or less. LC 4616.4(f).

The AD shall immediately adopt the decision of the IMR and promptly issue a written decision. (LC 4616.4(h).)

If IMRer finds disputed treatment or diagnosis consistent with Section 5307.27 or ACOEM, EE can seek disputed treatment from a physician of their choice from **within or outside the MPN.** LC 4616.4(i). See 8 CCR 9767.1, 9768.1-9768.17)

b. Appeal of the IMR Determination:

The IMR determination may be appealed only by verified appeal filed with the appeals board, served on all interested parties within 30 days of mailing of the determination. Lab. Code 4610.6(h) **Grounds for Appeal** of the IMR determination must be established upon proof of clear and convincing evidence of: (1) AD acted **without or in excess** of AD's power; (2) Determination was procured by **fraud**; (3) Material **conflict of interest** in violation of LC 139.5; (4) the

existence of race, national origin, ethnicity, religion, age, sex, sexual orientation, color or disability **BIAS;** (5) The determination was the result of **plainly erroneous** express or implied finding of fact based on ordinary knowledge. Lab. Code 4610.6(h). Any appeal is made even more difficult by the fact that the **IMR reviewer's name confidential**. Lab. Code 4610.6(f).

V. Miscellaneous Case Decisions

Edilberto Cerna Romero v. Stones and Traditions, State Compensation Insurance Fund, 2016 Cal. Wrk. Comp. P.D. LEXIS 142 (Board Panel Decision)

The applicant's PTP submitted an RFA for four different treatment modalities. The UR physician requested additional information pertaining to two of the treatment modalities and issued a decision within 14 days as required by Labor Code § 4610 as to all four of the treatment modalities. The WCJ reasoned that the UR physician should have issued a decision regarding the two treatment modalities for which no additional information was required within 5 days.

On reconsideration the WCAB disagreed holding that Rule 9792.9.1 provides that an RFA triggers the timelines for completing utilization review and does not contemplate different timelines for different treatment requests within a single RFA. Accordingly, the September 14, 2015 UR decision is timely as to all modalities requested as part of the RFA. See also, Favila v. Arcadia Health Care, Cypress Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 181 (Board Panel Decision) Labor Code § 4610(g)(1), 8 Cal. Code Reg. § 9792.9.1. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10; Sullivan On Comp, 7.35 Utilization Review – Time Limits.]

Bissett-Garcia v. Peace and Joy Center, Virginia Surety Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 174 (Board Panel Decision); Bissett-Garcia v. Peace and Joy Center, Virginia Surety Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 282 (Board Panel Decision);

On September 11, 2015, applicant wrote to defense counsel attaching a PR-2 report from primary treating physician. On the bottom of page 2 of the attached report the PTP wrote, "The patient requires home assistance with [activities of daily living]; 8 hours a day, 7 days a week for cooking, cleaning, self grooming and transportation." On the transmittal letter, applicant's counsel wrote, "Please see the attached PR-2, treating doctor's report from Dr. Vincent J. Valdez 9/08/15. Requesting authorization from home assistance 8 hours a day, 7 days a week. We are asking that this be authorized upon receipt of this letter."

Despite the fact that this "request for authorization" did not comply with Administrative Rule 9792.9.1(a) or Administrative Rule 9792.9.1(c)(2)(B) (Cal. Code Regs., tit. 8, § 9792.9.1, subds. (a) & (c)(2)(B)), defense counsel forwarded the request for treatment to the utilization review process established by defendant pursuant to Labor Code section 4610. On September 17, 2015, defendant's utilization review provider denied the requested treatment. The WCJ held the UR decision untimely and therefore that the WCAB had jurisdiction under Dubon to determine the issue of medical necessity.

On reconsideration the WCAB reversed writing that "according to the utilization review determination, Dr. Valdez's request for treatment was received by the utilization review provider on September 14, 2015. Pursuant to Labor Code section 4610(g)(1) and Administrative Director Rule 9792.9.1(c)(3) (Cal. Code Regs., tit. 8, § 9792.9.1, subd. (c)(3)), defendant had five business days to issue a decision to approve, modify, delay or deny the request. The time runs from the date that a request for authorization "was received by the claims administrator or the claims administrator's utilization review organization." (Administrative Director Rule 9792.9.1(a)(1); Cal. Code Regs., tit. 8, § 9792.9.1, subd. (a)(1).) Thus, defendant's utilization review determination was due September 21, 2015. The September 17, 2015 utilization review denial was well within the time limits. Thus Time limit for UR runs from the date the request for authorization "was received by the claims administrator or the claims administrator's utilization review organization" not from date defense attorney receives request. 8 Cal. Code Reg. § 9792.9.1(a)(1). [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10; Sullivan On Comp, 7.36, Independent Medical Review – Procedure; Sullivan On Comp, Section 7.34 Utilization Review – Request for Authorization.] But see conta, Czech v. Bank of America, 2016 Cal.Wrk.Comp.P.D. LEXIS 257 UR found untimely where defense attorney did nothing with request.

Favila v. Arcadia Health Care, Cypress Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS 181 (Board Panel Decision)

> *". . . Applicant's contention that the UR and IMR reviewers relied upon outdated medical treatment guidelines and not the most recent studies that applicant claims validate the requested surgery, ignores the mandate that a mistake of fact be of a "matter of ordinary knowledge . . . and not a matter that is subject to expert opinion." The question of whether the proper medical treatment guidelines were used to determine the appropriateness of the disputed surgical treatment is clearly a matter subject to expert opinion and is not a matter of ordinary knowledge. Furthermore, Labor Code section 4610.6(i) expressly precludes the WCJ, the Appeals Board or any higher court from making "a determination of medical necessity contrary to the determination" of the IMR organization. . ."*
>
> *Favila v. Arcadia Health Care, Cypress Insurance Company, 2016 Cal. Wrk. Comp. P.D. LEXIS at pg. 183 (Board Panel Decision)*
>
> *But see, contra, McAtee v. Briggs & Pearson Construction, 2016 Cal.Wrk.Comp. P.D. LEXIS 375(BPD), ordering that new IMR determination pursuant to Labor Code § 4610.6(i) was appropriate where WCAB found that UR determination was result of plainly erroneous express or implied finding of fact as matter of ordinary knowledge based on information submitted for review where IMR reviewer erroneously applied Medical Treatment Utilization Schedule (MTUS) guideline.*
>
> *See also, Gonzalez-Ornelas, v. County of Riverside, 2016 Cal. Wrk. Comp. P.D. LEXIS 151(BPD) where Applicant's IMR appeal pursuant to Labor Code § 4610.6(h)(1) and (5) granted, as IMR determination denying authorization based lack of documentation of diagnosis and failure of conservative treatment, where documentation on both existed and were provided to reviewer -- IMR determination was "plainly and directly contradicted" without need for "expert opinion" within "realm of ordinary knowledge". [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.11; Sullivan On Comp, 7.41, Independent Medical Review – Appeal and Implementation of Determinations]*

Applicant appealed the UR non-certification of the PTP's RFA for artificial disk replacement surgery to IMR. The IMR upheld the UR determination. Applicant than sought review by the Appeals Board arguing should order a second IMR review because the IMR determination was based upon a plainly erroneous expressed or implied finding of fact. Applicant asserted that there is a dispute over the appropriate applicable medical guideline for determining whether the proposed surgery is reasonable, asserting that the UR and IMR physicians relied upon outdated medical information as to the efficacy of the artificial disk replacement surgery.

Labor Code section 4610.6(h) limits the grounds for an appeal from an IMR determination, which determination is "presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:" The ground for appeal cited by applicant is set forth in section 4610.6(h)(5): The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and *not a matter that is subject to expert opinion*.

The WCAB held that a UR denial based on outdated medical treatment guidelines, is not a proper basis for IMR appeal as "plainly erroneous express or implied finding of fact" as described in Labor Code § 4610.6(h)(5) which requires that mistake of fact be matter of ordinary knowledge, not matter subject to expert opinion, and that whether proper medical treatment guidelines were used to determine appropriateness of disputed surgical treatment is clearly matter of expert opinion and not grounds for IMR appeal. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.11; Sullivan On Comp, 7.41, Independent Medical Review – Appeal and Implementation of Determinations]

King v. Comppartners, Inc., (2016 4th Appellate District) 243 Cal. App. 4th 685; 196 Cal. Rptr. 3d 696; 81 Cal. Comp. Cases 10; 2016 Cal. App. Lexis 2.

Applicant sustained injury to back on 2/15/08 and suffered anxiety and depression due to chronic back pain resulting in the psychotropic medication Klonopin being prescribed. In July 2013, a workers' compensation utilization review was conducted to determine if the Klonopin was medically necessary. (Lab. Code, § 4610, subd. (a).) The UR physician determined the drug was unnecessary and decertified it, with applicant required to immediately cease taking the Klonopin. Typically, a person withdraws from Klonopin gradually by slowly reducing the dosage. Due to the sudden cessation of Klonopin, King suffered four seizures, resulting in additional physical injuries. In September 2013 as second authorization request for Klonopin which was submitted to UR and by a second UR physician determined Klonopin was medically unnecessary. Neither UR physician examined applicant in person, nor warned applicant of the

dangers of an abrupt withdrawal from Klonopin. Applicant filed a civil complaint seeking damages for negligence arguing that the UR physician owed the applicant a duty of care, which was breached by failure to warn and/or failure to recommend weaning. Defendants demurred to the complaint contending the Labor Code set forth a procedure for objecting to a utilization review decision, and that procedure preempted the Kings' complaint. Alternatively, defendants asserted that the UR physicians did not owe applicant a duty of care. Defendants argued there was no doctor-patient relationship because they never personally examined Kirk and did not treat him. Defendants reasoned that because there was no relationship, there was no duty of care. The trial judge granted defendant's demur without leave to amend.

The Court of Appeal reversed holding that the UR physician has physician-patient relationship with person whose medical records are being reviewed and, thus, owed applicant a duty of care, that determination of scope of duty owed depends on facts of case, and that, to the extent plaintiffs are faulting utilization review physician for not communicating warning to applicant, their claims are not preempted by exclusivity rule of workers' compensation. Demur sustained with leave to amend. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][c], [d], 22.05[6][b][iii], [iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10[6][b], [7][b].]

Arredondo v. Tri-Modal Distribution Services, 80 Cal. Comp. Cases 1050; 2015 Cal. Wrk. Comp. LEXIS 112 (W/D)

On 10/25/2013, Applicant's primary treating physician, submitted requests for medications, a back brace, and physical therapy. Defendant timely issued a UR determination denying certification. Applicant timely appealed the UR determination through IMR on 12/24/2013 and again on 12/30/2013. On 3/25/2014, before the IMR determination issued but after the timeframe specified in Labor Code § 4610.6(d) for issuance of IMR decisions, Applicant filed a DOR to proceed to expedited hearing regarding his entitlement contending that the IMR determination was invalid because it did not issue within the 30-day time limit described in Labor Code § 4610.6(d) and argued that, because there was no valid IMR, the WCAB had jurisdiction to resolve the parties' dispute over Applicant's entitlement to the requested medications. WCJ concluded that the Administrative Director's failure to issue an IMR determination within the specified time-period did not invalidate the IMR to allow the WCAB to determine medical necessity. Applicant sought reconsideration.

> *See also, accord, SCIF/California Highway Patrol v. WCAB (MARGARIS), 248 Cal. App. 4th 349; 2016 Cal. App. LEXIS 491; Also see, Bolton v. County of San Bernardino, 2016 Cal. Wrk. Comp. P.D. LEXIS 224 (Panel Decision) holding the need for peer review is not exception listed in 8 Cal. Code Reg. § 9792.9.1(f)(1) for extension of 5 day timeframe. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2][c], 22.05[6][b][iii]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10[4]. Sullivan On Comp, 7.35, Utilization Review]*

By split panel decision the WCAB upheld the WCJ. The WCAB held that they lacked jurisdiction to review timely utilization review non-certification of requested medical treatment despite the Administrative Director's alleged failure to timely complete independent medical review reasoning that Labor Code § 4610.6(d) timeframes are discretionary, not mandatory, and, therefore, independent medical review determination is valid even if it does not issue within specified timeframes.

Morales v. Pro Armor, 2016 Cal.Wrk.Comp. P.D. LEWIS 378 (BPD)

Applicant after having been released from further care by her MPN PTP, began self -procuring treatment outside of the MPN. At lien trial applicant testified that she was referred for medical treatment by her employer the day after she sustained an injury in a slip and fall accident on September 8, 2011. She testified that she reported injury to her head, shoulders and back for which she was provided treatment in the form of x-rays and medication. After she was released from further treatment by defendant's MPN physician, she obtained legal representation, who referred her to a non-MPN physician who referred her to lien claimant for her psychiatric complaints, which applicant testified first developed after she was told she was being laid off from work. Lien claimants

> *. . .If Applicant objected to her treating physician's opinion to release her from care she was required to resolve that dispute by the procedures provided in Labor Code § 4061 and 4062. In this case, Applicant failed to comply with those procedures. Applicant simply elected to treat with a non-MPN doctor, Dr. Rahman. . .*
>
> *Morales v. Pro Armor, 2016 Cal.Wrk.Comp. P.D. LEWIS at pg. 382*

included non-MPN treatment costs and associated translation services. The WCJ denied the lien holding that once applicant was released from care, the applicant could only contest via the MPN procedures pursuant to LC 4616.3 or medical-legal procedures contained in LC 4061 and 4062.

The WCAB held Defendant not liable for lien of non-MPN treatment as no evidence of denial of care, and after release from further medical care with no work restrictions or need for further medical treatment by MPN treater, applicant may only contest the MPN treater's opinion via MPN procedures pursuant to Labor Code § 4616.3, or med-legal procedures pursuant to Labor Code §§ 4061 and 4062. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03[4]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[8][b].]

Luna v. The Home Depot, 2016 Cal. Wrk. Comp. P.D. LEXIS 405 (Split BPD)

> *§ 9767.5. Access Standards*
>
> *(a) A MPN must have at least three available physicians of each specialty to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged and within the access standards set forth in (1) and (2).*
>
> *(1) An MPN must have at least three available primary treating physicians and a hospital for emergency health care services, or if separate from such hospital, a provider of all emergency health care services, within 30 minutes or 15 miles of each covered employee's residence or workplace.*
>
> *(2) An MPN must have providers of occupational health services and specialists who can treat common injuries experienced by the covered injured employees within 60 minutes or 30 miles of a covered employee's residence or workplace. . .*

Applicant filed a Petition to Reopen for New and Further Disability on September 10, 2015. He subsequently filed a Declaration of Readiness to Proceed to Expedited Hearing on the issue of his entitlement to obtain medical treatment outside defendant's MPN, due to the absence of orthopedists to act as his primary treating physician within 15 miles of his home or his employer's zip code.

The matter was tried on June 16, 2016, on the issue: "Whether Applicant is entitled to treat outside of the MPN with a physician of his own choice due to Defendant's failure to comply with MPN access standards set forth in Title 8, CCR 9767.5(a) and 9767.5(a)(1)." The parties stipulated that "there is one orthopedic surgeon within 15 miles and seventeen orthopedic surgeons within 30 miles from the injured worker's residence and the employer's zip code."

The WCJ concluded that because applicant sought an orthopedic surgeon, a specialist, to be his primary treating physician, the MPN need only meet the 30 mile/60 minutes access standard for selection of a specialist and not the 15 mile/30 minute access standard applicable to the selection of a primary treating physician.

WCAB panel majority found that because applicant sought specialist in orthopedic surgery to be his primary treating physician, defendant's MPN need only meet 30 mile/60 minute access standard for selection of specialist under 8 Cal. Code Reg. § 9767.5(a)(2) and not 15 mile/30 minute access standard applicable to selection of primary treating physician under 8 Cal. Code Reg. § 9767.5(a)(1).; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[4].]; Sullivan on Comp, Section 7.53, Medical Provider Network – Establishment and Maintenance.

Farias v. Able Building Maintenance, Zurich North America, 2016 Cal. Wrk. Comp. P.D. LEXIS 440 (Board Panel Decision).

> *Editor's Comments: First be advised this is a split panel decision and therefore is of limited value. Second, note that Commissioner Sweeney in here dissenting opinion I believe raised the real issue: if the transfer of care requirements are absent from the CBA, either Labor Code Section 4603.2 should be applied or the CBA provisions concerning applicant's entitlement to medical treatment should be deemed "void" as a diminishment of applicant's California Workers' Compensation Benefits. Though. Collective bargaining the employer should not be allowed to reduce Worker's Compensation benefits but merely to create an alternative delivery system.*
>
> *In conclusion, the majority's decision in Farias is best summarized as holding that where the medical treatment is "negotiated" pursuant to a CBA, it does not really matter what the specific provisions of the medical treatment benefit are or whether those provisions serve to diminish the employee's rights to medical treatment under the Workers ' Compensation System. According to the State of California's statistics, there are at least 34 ADR programs operating in California. As more ADR's are established, how Labor Code Section 3201.5(b)(1) and Labor Code Section 3201.7(b)(1) are interpreted will become increasingly important.*

By split panel opinion, applicant who suffered CT ending 1/22/14 and was treating outside of alternative dispute resolution (ADR) agreement based on denial of her claim by defendant, was required to transfer treatment to ADR agreement's exclusive provider network after defendant accepted her claim, pursuant to provisions in Labor Code § 3201.5 and terms of ADR agreement reasoning that (1)that agreed list of medical providers in ADR agreement differs from medical provider networks (MPN) established pursuant to Labor Code § 4616, (2) that MPNs are

regulated by Administrative Director and subject to statutory constraints such as those in Labor Code § 4603.2(a)(2) addressing transfer of treatment into MPN, (3) that Labor Code § 3201.5 allows use of agreed list of treaters and allows parties to agreement to negotiate any aspect of medical treatment delivery, (4) and that MPN statutes, including Labor Code § 4603.2, do not apply to medical treatment negotiated pursuant to collective bargaining agreement.

Noteworthy was Commissioner Sweeney dissenting opinion. Commissioner Sweeney noted that since ADR agreement was silent on transfer of care after employee has self-procured treatment from provider who is not on agreed provider list, and there was no dispute resolution mechanism for this dispute, MPN provisions in Labor Code, which allow employee to continue treatment with doctor outside employer's MPN when there has been final determination that employee was entitled to treat outside MPN. Requiring applicant to transfer care is a diminishment of applicant's entitlement to medical benefits and that portion of bargaining agreement that diminishes applicant's entitlement to benefits should be held null and void as a matter of public policy. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 1.04A; Rassp & Herlick, California Workers' Compensation Law, Ch. 3, § 3.04[3]; Sullivan on Comp, Section 3.5, Carve-Outs.

Lambert v. State of California Department of Forestry, SCIF, 2016 Cal. Wrk. Comp. P.D. LEXIS 492 (BPD)

Applicant sustained an admitted injury to his left knee on February 7, 2015, while employed as a firefighter by California Department of Forestry and Fire Protection. Applicant's PTP performed a surgical repair of the medial meniscus on October 24, 2015. Applicant was provided physical therapy prior and subsequent to his surgery. The parties stipulated that applicant had at least 28 post-operative physical therapy visits. Applicant's PTP submitted an RFA for an additional eight physical therapy visits. Defendant's claims adjuster issued a denial of the request on May 26, 2016, citing the 24 physical therapy visit cap in Labor Code section 4604.5(c)(1). The additional RFA of 8 PT visits was not submitted to UR, rather the adjuster relied on a pre-surgical denial based upon pre-surgical PT totaling 24 visit. Applicant's attorney responded on May 31, 2016, noting that the 24 visit cap on physical therapy cited by defendant's claims adjuster was not applicable to post-surgical physical therapy, and he demanded that defendant immediately authorize the requested treatment. The matter was submitted on this record at an expedited hearing.

The WCJ held that when treating physician submits RFA for medical treatment, the UR Physician, not claims adjuster, is required to apply MTUS to determine medical necessity of proposed treatment, and that since application of MTUS post-surgical guidelines was required to determine whether additional physical therapy visits were medically necessary to treat applicant's injury, it was beyond claims adjuster's authority to apply MTUS to deny treating physician's RFA, and RFA should have been submitted to UR for review by licensed physician. However, Labor Code section 4604.5(c)(1) sets a 24 visit cap on physical therapy visits "notwithstanding the medical treatment utilization schedule." However, this cap is not applicable to physical therapy visits for "postsurgical physical medicine and

"Labor Code section 4604.5(c)(1) sets a 24 visit cap on physical therapy visits "notwithstanding the medical treatment utilization schedule." However, this cap is not applicable to physical therapy visits for "postsurgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27." (Labor Code section 4604.5(c)(3).)

Applicant was correct in asserting that since this was a postsurgical treatment request, SCIF's claims adjuster erroneously relied on the 24 visit cap in Labor Code section 4604.5(c)(1) when he denied Dr. McLennan's request.

When considering requests for medical treatment for post-surgical knee complaints, the MTUS provides:

> *(d) If surgery is performed in the course of treatment for knee complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply. (Cal. Cod Regs., tit. 8, section 9792.23.6 Emphasis added.)*

When a treating physician submits a Request for Authorization for medical treatment to a claims adjuster, Labor Code section 4610(e) provides that only a licensed physician "may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve." Thus a reviewing physician, and not a claims adjuster, is required to apply the MTUS when determining the medical necessity of a proposed medical treatment. (Labor Code section 4610(f).)"

Lambert v. State of California Department of Forestry, 2016 Cal. Wrk. Comp. P.D. LEXIS at pg. 494

See, Garcia, v. American Tire Distributors, Broadspire, 2016 Cal. Wrk. Comp. P.D. LEXIS 527 (BPD), where the Board held that an agreement between the parties to resolve a single medical issue through the use of an AME pursuant to LC 4062(b) cannot be used to avoid application of the UR/IMR process pursuant Labor Code §§ 4610 and 4610.5. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11. Sullivan on Comp. Section 7.36, Utilization Review -- Procedure]

See also, Hogenson v. Volkswagen of America, Insurance Company of the State of Pennsylvania, 2016 Cal. Wrk. Comp. P.D. LEXIS 488 (BPD, holding that RFA from MPN treating physician is subject to UR/IMR process, which is consistent with the legislative goal of assuring that medical treatment is provided by all defendants consistent with uniform evidence-based, peer-reviewed, nationally recognized standards of care; Commissioner Sweeney concurring separately noted two separate statutory tracks to dispute recommendation of MPN treating physician, consisting of UR IMR (employer objects) and second opinion MPN IMR process (applicable when employee objects); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]. Sullivan on Comp, Section 7.55, Medical Provider Network – Dispute Resolution]

See also, Rivas v. North American Trailer, 2016 Cal. Wrk. Comp. P.D. LEXIS 572 (BPD) holding that Applicant may properly select individual physician not individually listed on employer's MPN where physician's medical group is listed, and MPN medical groups employs services of physicians who do not register individually with MPN; WCAB interpreting Labor Code § 4616(a)(3) and 8 Cal. Code Reg. § 9767.5.1. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 5.03[1]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.12[2]. Sullivan on Comp, Section 7.53, Medical Provider Network.]

postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27." (Labor Code section 4604.5(c)(3).); [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§5.02[2][a], [b], 22.05[6][b][i], [ii]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, § 4.10[6].]

See, Gonzalez v. Imperial County Office of Education, 2016 Cal. Wrk. Comp. P.D. LEXIS 528 (BPD), holding that dismissal without prejudice be rescinded where when medical reports established diagnosis of agoraphobia and panic disorder and applicant was medically unable to appear in court; Due process required accommodations such as being permitted to appear telephonically or via Skype [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 26.01[3][b], 26.04[1][c]; Rassp & Herlick, California Workers' Compensation Law, Ch. 16, § 16.07[2][b]. Sullivan on Comp, Section 15.37, Requirement to Appear at Hearing.]

See, Williams v. Department of Corrections & Rehabilitation, 2016 Cal. Wrk. Comp. P.D. LEXIS 511(BPD) holding that it was error for WCJ to order former counsel to attend hearing as witness rather than by subpoena pursuant to Cal. Code Civ. Proc. § 1985, and the subpoena must be personally served as required by Cal. Code Civ. Proc. § 1987. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 1.11[3][g], 25.10[2][a], 26.03[4], 26.05[3]; Rassp & Herlick, California Workers' Compensation Law, Ch. 15, § 15.45[1], Ch. 16, § 16.48[1], Ch. 19, § 19.37. Sullivan on Comp, Section 15.47, Trial – Proceedings and Submission]

See, Bonilla v. San Diego Personnel and Employment dba Good People Employment Services, 2017 Cal. Wrk. Comp. P.D. LEXIS 56 (BPD), holding that treatment requests from all physicians, even those treating within MPN, must go through UR/independent medical review (IMR) process mandated by Labor Code § 4610 et seq., and that existing law requires RFAs for medical treatment be utilized by MPN physicians and are subject to all UR requirements.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]; Sullivan on Comp, Section 7.34, Utilization Review – Requests for Authorization.] See also, Parrent v. Workers' Compensation Appeals Board, Pacific Bell Telephone Co. SBC, 82 Cal. Comp. Cases 155; 2017 Cal. Wrk. Comp. LEXIS 3 (Writ Denied), holding that treatment recommendations of medical provider network treating physician, may only be disputed through utilization review/independent medical review process; Commissioner Sweeney, concurring, wrote separately to emphasize that, even if employer raises dispute with medical provider network treating physician's recommendation and submits issue to utilization review, injured worker may, at same time, exercise his or her right to initiate second opinion process provided in Labor Code § 4616.3 or change treating physicians within medical provider network.; [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02[2], 5.03[4], [5], 22.05[6][b][iv]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11, 4.12[8], [9]. Sullivan on Comp, Section 7.55, MPN -- Dispute Resolution]

Federal Express Corporation v. WCAB (Paynes) 82 Cal. Comp. Cases 1014, 2017 Cal.Wrk.Comp. LEXIS 91

Applicant sustained a specific injury on 2/25/97 to various parts of body to include bilateral knees. The claim was settled via C&R with open medical treatment with AME Peter Mandel to decide issues regarding reasonableness and necessity for future medical care. In 2015 the PTP reported that Applicant was a candidate for left knee total arthroplasty after she lost weight. Defendant's UR denied the weight loss requested extension, and the UR denial was upheld by IMR. Thereafter Dr. Mandel issued a report indicating that Applicant needed an additional six months of the weight loss program to enable a left knee replacement.

Applicant filed a DOR requesting an expedited hearing on the issue of her entitlement to an extension of the recommended weight loss program, seeking to enforce the C&R stipulation that the parties would utilize AME Dr. Mandel on future issues of treatment. Defendant objected to the DOR, asserting that the requested treatment was denied by UR/IMR, and that the WCAB had no jurisdiction over the medical treatment dispute.

The matter proceeded to a trial, with the WCJ agreeing with Defendant and concluded that he had no jurisdiction to decide the necessity of the weight loss program since Applicant triggered the IMR process by appealing the UR denial. The WCJ stated, however, that, had the IMR appeal not been filed, he may have allowed the weight loss program, based on Dr. Mandel's opinion and the WCAB's holding in *Bertrand v. County of Orange*, 2014 Cal. Wrk. Comp. P.D. LEXIS 342(Appeals Board noteworthy panel decision).

On reconsideration the WCAB reversed holding that the 2003 agreement within C&R to utilize AME on issues of future medical treatment was enforceable despite statutory changes implementing utilization review/independent medical review citing *Bertrand v. County of Orange*, 2014 Cal. Wrk. Comp. P.D. LEXIS 342 (Appeals Board noteworthy panel decision). The WCAB also seemed to allow in this limited situation the applicant to proceed both as the to UR/IMR procedures and pursuant to the Stipulation within the C&R. [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 5.02, 22.05[6]; Rassp & Herlick, California Workers' Compensation Law, Ch. 4, §§ 4.10, 4.11.]